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CONTENTS

Page

Fear of Leaving the Apartment
—Edmund Bergler ... 281

Garo Songs—T. C. Sinha ... 285

Some Aspects of the Unconscious in Hysteria
—Nagendranath De ... 299

Prof. Freud : The Beginning of a Case History
—Paul Federn ... 305

Memorandum on the Problems of Prevention and Treatment of Mental Disorders submitted to the Medical Relief Advisory Committee of the Health Survey and Development Committee, Government of India—G. Bose ... 312

Extracts from the Recommendations of the Bhore Health Survey and Development Committee, Government of India ... 325

Abstracts ... 341

Notes and News ... 343

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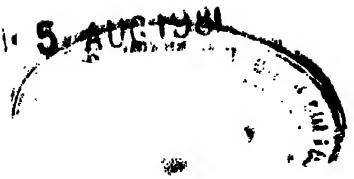

FEAR OF LEAVING THE APARTMENT

EDMUND BERGLER, M. D.

Fear of leaving home, or apartment, is encountered in many neurotics, independently of the specific symptom or sign which is in the foreground. That fear is most typically produced in sufferers of street-fear (agoraphobia), in both subtypes, the 'exhibitionistic' and the 'aggressive' ones. In the former, the neurotic protects himself from his own repressed exhibitionistic desires, shifted upon the harmless street. In the latter, remaining home denotes 'proof' of 'protecting' the person against whom repressed death-wishes are directed; by clinging to that person, proof positive is adduced that the "omipotence of thought" (Freud) has been ineffective in killing. Seeing the unconsciously hated person alive is a from of reassurance. If that type of agoraphobe leaves home at all, then he must be accompanied by the "protected protector" (H. Deutsch). Frequently a combination of both types of agoraphobia is seen clinically[1].

In other cases, different unconscious reasons are responsible, as for instance, in hypochondriacal neurotics (especially those afflicted with heart-neurosis) the preference for staying at home is alleged to be based on the expectation of an heart attack, and the rationalization of getting quicker medical attention and help. In neurotics with paranoid 'colouring', the imaginary persecutor is avoided, etc. The deeper *real* reasons must be analysed. In all these cases, home has, as repeatedly stressed in the literature, the symbolic connotation of the 'protecting' mother.

All that is known. I would like to describe a specific type of the fear of leaving the apartment, which has a different substructure. In these. cases, none of the enumerated reasons is decisive, and the *basis* is a conplicated fight with *repressed psychic masochistic components.*

Mrs.A., a woman of 31, came into analysis because of patho-

1. See the author's "Psychoanalysis of a Case of Agoraphobia", The Psychoanalytic Review, 1938.

logic fears connected with her son aged eight. She was on the constant look-out for some sickness of the child. She took his temperature twenty times a day : every coughing was interpreted as incipient pneumonia. If the child was in school, the mother worried, whether or not, he was warm enough only to revert a few minutes later to the opposite fear, dreading the thought that he was too warmly dressed. During the night, she could not decide whether the window in his room should be closed or remain open. She changed her mind constantly and acted according to the last doubt, only to reverse her decision shortly afterwards.

These obsessional doubts had, as was to be expected, superficially the unconscious meaning of fight between two contradictory tendencies : repressed hatred and guilt-love, both directed toward the innocent boy. In my opinion[2] the superficial, though unconscious aggression so typical in obsessional neurotics, is but pseudo-aggression, covering deeper repressed masochistic tendencies. Thus, a three-layer structure is discernible : masochistic attachment, warded off with pseudo-aggression, secondarily warded off with pseudo-love. The decisive point in Mrs A.'s hyper-solicitude had, however, nothing to do with the child. She was fighting an anachronistic battle with her own mother, choosing as battle-field her child. She acted a "magic gesture". A magic gesture of that type denotes unconscious dramatization of the accusing thought : "I shall show you in my behaviour how I wanted to be treated kindly and lovingly". In other words, the patient, Mrs.A., still could not forgive her mother's interest in the younger brother and sister.

If one probes deeper into "magic gestures" one finds that only psychic masochists make extensive use of those. Their basic unconscious fixation belongs to the "rejection level". These neurotics left their childhood with the pathologic elaboration of their alleged grievances : instead of overcoming the 'rejection', they become attached to it. They repeat later in life self-constructed 'disappointments.' Against that enjoyment of defeats, their

2. For details see "Two Forms of Aggression in Obsessional Neurosis", The Psychoanalytic Review, 1942 ; "The Leading and the Misleading Basic Identifications", ibid, 1945.

inner conscience objects, with the effect that an inner defense mechanism has to be established. Its content is: "I am not masochistically attached to mother, quite the contrary, I hate her", Since, however, one "cannot do business" with the unconscious conscience, the alibi of pseudo-aggression is rejected too, the result is that a secondary alibi is established: "Neither do I hate mother, nor am I masochistically attached to her. I just show her in my behaviour how I wanted to be treated by her kindly". That defense constitutes the "magic gesture."[3] In her hypersolicitude for the boy, Mrs. A. acted such a "magic gesture", even to the point of caricature.

All that was worked out in analysis with Mrs. A. with beneficial effect. One day, she remarked that she is "scared to death" of her approaching vacation tour in Canada. It turned out that this symptom, which she had not previously mentioned, consisted of fear of leaving home, and appeared only if the absence was protracted for a series of days. "Why I should be frightened, is not understandable to me. I hate staying in New York, the boy is in camp, my husband and I both need and want that vacation. By the way, it was always so: every vacation, more, every little excursion involving leaving home for a few days, produces automatically that fear."

First, the connection of this fear with the child had to be excluded. That was simple enough, since the fear of leaving home made its appearance whether the child accompanied her or not. In the specific instance, the boy was in camp, and still her fear was very predominant.

It turned out that her mother, the main point of attachment of her neurotic masochism, lived in the same building. "By chance", Mrs. A.'s apartment was chosen in her mother's vicinity. That chance was unconsciously meaningful. Seen in slow motion, Mrs. A.'s fear of leaving home had these layers: Layer I (end result of the infantile conflict), "I want to be masochistically rejected and tortured by mother, I want to stay home to be the object of her wrath." Layer II (first super-ego reproach), "You have no

3. "The Problems of Magic Gestures," The Psychiatric Quarterly, 1944.

right to enjoy the masochistic wish." Layer III (first defense, created by the unconscious ego), "I am not masochistically attached to mother; I hate her and feel guilty. I want to stay home to protect her from the result of my bad wishes (omnipotence of thought)" Layer IV (second super-ego reproach), "You have no right to be aggressive, either." Layer V (second defense of the unconscious ego). "I am neither masochistic, nor aggressive. I want to stay home because I'm sick and am afraid of aggravations on vacations."

This and similar cases convinced me that in some specific instances, the fear to leave the apartment, has a complicated and hitherto undescribed, masochistic substructure.

GARO SONGS

T. C. SINHA

The Garos live in the district of Garo Hills in Assam. The population of the district is 2,25,000 approximately. I discussed in a previous lecture in the Society the geography of the district and also about the mode of life of this half naked, uncivilized aboriginal tribe of Assam. I shall not therefore repeat them to-day. For the benefit of these who were not present then, I shall mention only that the Garos mainly live in the Garo Hills. They build their houses generally on the slopes of the hills, on piles of bamboo, raised from the ground, and cover the roof of the cottage with a variety of long blade grass known as *hamfang*. They have usually only two doors in the house and no window. Married couples and unmarried girls live in the same house, but young bachelors are sent to the bachelors' dormitory called *nokpante*. The property is vested in the mother, from her it goes to the daughter selected by the mother by inheritance. The Garos eat rice and dried fish soup and meat when available. Vegetables of local growth are also included in the dietary. They are of strong build and of medium height and are rather dark in complextion. They like to idle away their time rather than do any work. But whether willing or unwilling they have to work hard for their food. It is really difficult to prepare the slopes of the hills for cultivation. The Garos are poor and do not appear to be ambitious. They seem to be contented with the little they have. Garo Hills, is a good place for *shikaries*. Birds of diflerent varieties and big games of various kind from wild boars to elephants and tigers abound in the hills.

The Garo hill elephants are known to be the most beautiful in the whole world. The district is very densely covered with forests of timber trees and undergrowths. In places the forest is so thick that even the mighty wild elephants cannot make

* Read before the Indian Psycho-analytical Society on the 5th April, 1942

their way through. This, in short, is the land where the Garos live.

At the very beginning I should tell you that in a Garo village the sound of the big drum called *krum* and that of the *adel* or the horn, and that of the *rung*, a metal bell which is considered to be very valuable by the Garos, could be heard at any time of the day and night coming from the nokpante i. e. the bachelors quarter. It is the usual custom of the Garos to keep the musical instruments in the nokpante. Married men and women usually do not sing songs in the house they live in unless there is some special ceremonial occasion. It is the practice of the Garos to sing during the festivals such as Wangala, Rongchugala and others. The musical party is composed mainly of the *panthe* i. e. (bachelors) and the *numils* or the unmarried girls. Married men may also join the party but I have not seen married women taking part in the music except on rare occasions.

The girls dress in their best and put a small turban on their head, into which is stuck some bright long tail feathers of the cock. The girls stand together and the men folk dance their war dances around them with *mellam* i. e. a Garo sword in their hands and sing songs which are usually answered by the girls in their turn. The girls move but little and very slowly at the center of the circle formed by the men folk. *krum*, *adel*, *rung*, and *fongsi* (bamboo flute) are played in accompaniment. Liquor prepared by fermenting boiled rice, is freely drunk by every one present both male and female, young and old including even the babies in arms. The spirit goes high and gradually people begin to fall victims to excess of alcohol and many drop down senseless.

Some of these festivals continue for three consecutive days and nights. Besides the regular festivals musical parties are organised on other occasions also, such as : (1) after the completion of the construction of a house, (2) when the different crops are brought from the fields and stored in the granary, etc., (3) during the *delangsua* i. e. the burning ceremony of the small shade built to house the *mimang* (the spirit of the dead) and such other occasions.

There are mainly seven different varieties of Garo songs, sung on different occasions. They are: (1) Gonda. (2) Ajia. (3) Re Re. (4) Dani. (5) Chera. (6) Doro. (7) Ahama. Of these seven varieties the first three i.e. Gonda, Ajia and Re Re are more commonly sung. Gonda and Ajia are to a very great extent similiar in their composition and tune. Gonda is widely sung by the different sects of the Garos, namely Atong, Matchi, Garo, Ganching and others. While Ajia is sung mainly by the Atong group and Re Re by the Duals and the Ruga groups. Dâni and Ahama are sung by the Matchi people mainly. Chera is sung by the Chisak and also by some other groups on special occasions. It seems that some of the Doro and Chera songs are very old and are composed in old dialect, the meaning of which is not familiar to the singers of the present day. The Garos think that in their songs there are references to old incidents mythical or real. They seem to have some reverence for these old verses though they do not understand the meanings of the words contained in them. These songs have come down to the present generation through the ages from father to son. It is therefore not unlikely that the original verses have changed or have been distorted by ommissions, additions, etc. This factor by itself may have added to the difficulty in understanding the language of the verse. When asked about the meaning of these songs the garos say, "these were composed by the men of old old days, long long ago ; we do not know the meaning of the words they used, they were different from ours." There are people in many villages who can compose new verses for Gonda, Ajia and Re Re songs. In fact they composed many such songs in my name when I went to their villages. Some of these newly composed verses become standard songs in course of time while others are forgotten or never sung again. Usually such verses are songs of the moments and are composed for fun.

It is not possible to deal with the whole field of Garo songs in a short paper like this. I shall therefore try to concentrate on only one class of songs namely Gonda song. I have already told you that on ceremonial occasions Gonda is sung in duet form by two groups of singers, one male and the other female, usually both

unmarried. When one group sings one verse the other group replies to it or sings another verse, and so on.

In most cases the Gonda song consists of four lines of which the only second and the fourth lines rhyme. There are Gondas having two lines only but they are not so numerous as the four lined ones. There are Gondas again which do not appear to have any rhyme. These three classes of Gonda verses will be best understood from the following examples.

1) Two lined Gonda :

Nokpanthenī mīara
Dīal nangmong jorārā.

(Oh youth of the bachelor's house, your sweetheart has joined you)

2) Four lined Gonda having the second line rhyming with the fourth line :

Mukkhā wasosīanā
Bangal sātthī onjāwā
Chūgan sāregijādé
Dīalthangkho wātjāwā.

(The rain is drizzling, I do not want a Bengal umbrella ; until the Chungan festival is over, I will not let my darling go.)

3) Gonda having no rhyme :

F 397 Thring Thring bolgeppā
Selgāsaknī jongsénć
Bāju dengol enggodć
Hābućbo Simsangchi

(The insects fly upwards high up in the sky. If you feel the heat of the day, darling, take your bath in the waters of the Someswari river.)

4) There are some irregular Gondas which have only three lines :

Bilchinā dogeppā
Ridik Nāthok nāsālā
Chugānnānū būlsālon

(The Ridik fish is going up the stream towards the water of the lake. The time for the Chungan festival is drawing near)

The most striking characteristic of these songs is that

in most of the poems the first two lines describe (i) some incident from the daily life or (ii) some natural scenery or (iii) it depicts some situation from the animal or bird life, and in the last two lines, in almost all cases, some phase of the love life is touched upon. This will help us to understand the situation expressed in the poem more clearly. I shall describe it in detail presently.

The manner in which these Gondas are sung reminds one of the 'Kabi' song in Bengali. In the 'Kabi' song, the leader of one party, puts some question to the leader of the opponent party who in his turn gives his reply and the music goes on. In the case of the Garo Gonda also, the two parties mentioned before behave in the same manner but there is some difference. In the case of 'Kabi' song the questions mainly refer to Puranic or mythological stories, while in the Garo Gonda the question expresses some desire of the person putting it. In some cases there may not be a question at all but only an expression of opinion.

The influence of the English and the Bengali languages can be easily traced in some Gonda Songs. The influence of the Bengali language is more clearly manifested in the Re Re songs sung by the Dual and Ruga group of the Garos.

I shall cite some examples here :—

F (812) Habreo nógāmo
Nekkā *rumāl* bāroboko
Khennergmā nāngjiknā
Suruk *goppo* Khalbonā

(Looking from the hill top downwards, I have seen the waiving of your kerchief. Are you afraid of your wife in coming to me and speaking to me in whispers.)

Here the two words '*rumal*' and '*goppo*' have been taken over from Bengali.

(815) Khāmbāroknā ēnnodé
Uā māi borwāi
Diāl chukho ringjāmā
Memborbā dākjāwā.

(What is that timber you want to use for making your post ? Wont you drink the wine dear ? Wont make you a 'member' otherwise.)

Here the words '*Dial*' which is a modification of the word

dear and the word and '*Member*' are definitely English words. In the song 'member' means an exalted personage such as a member of the Legislative Assembly. It is well known that I and r are interchangeable phonetically ; Thus the word *dear* has become *dial* in the Garo song. The influence of the Bengali language can be further traced in the names of some of the deities which the Garos worship, such as, *Kamakha, Kali, Hashi, Khusi, Rishi, Nagini*, etc. The Garos have only recently come into touch with the educated class and the missionaries who speak in English. The number of the English words that have found admittance to the Garo vocabulary is naturally much less than that of the Bengali words.

I shall now say a few words about the sexual aspect of the Gonda songs of the Garos. Gonda is mainly sung during the festivals. During every festival drinking of liquor plays an important part. In fact the extent of the enjoyment and the importance of the festival is measured by the quantity of liquor consumed. People go far beyond their means to make a success of the festive ceremony and are thereby improverished. It appears, they have no thought of the future. They want to get repeated experience of the pleasure associated with drinking. Both men and women find scope for mixing more freely and of having illicit intercourse during the festival periods. I was told that love making often begins at the time of these festivals and it ultimately ends in matrimony. Behaviour that is not permitted in daily life, such as touching the body of a person of the opposite sex other than one's near relation is not objected to during such festivals.

During festivals the suppressed sexual desire finds a comparitively easy expression. But the social injunctions are not completely abrogated at any time. The repressed desires therefore come out in symbols in their songs. In some cases the sex desire is expressed openly and in other casses they remain more hidden behind symbols. It will be easy to understand from the following examples the sexual expression of Gonda songs.

M Hāding dingo dobifā
Numél pānthe noksikchi déknokā

(On the top of a steep hill-side the cock is crowing. There at

the corner of the house the unmarried girl and the boy are in a bent posture.)

M Sekkhrangoni chāgepā
Thirikmonā rātchiān,
Thopthopā rojājok
Manisoknā ékchiā

(The wild plantain tree that yields potash has already sprung up from the ground. I hate my maternal aunt's breasts which do not spring when pressed.)

It will be helpful to undetstand this song when you know that according to Garo custom it is the usual practice for the son to be married to his maternal cousin sister and that he goes to live in the family of the bride after marriage. After the death of the maternal uncle the nephew son-in-law, marries the widow mother-in-law. Thus both the daughter and mother are married to the same person. In the above mentioned song the son-in-law expresses his dislike for the sagging breasts of the old mother-in-law wife. Psycho-analytically the song represents an oedipus situation with resistance. The sprouting plantain tree that yields potash represents the penis and the ash that it yeilds is the semen. The ash can only be obtained by destroying the tree. Castration threat which inhibits the oedipus wish is suggested by this analogy.

M Ruri fālā khuéthom
Rāe chābo felsini
Diāl goppo khānaodé
Wālo rebā khāsinné

(The people of the plains sell sweets made of parched rice, Buy seven pice worth of it and eat. If you want to have a talk with me come secretly at night.)

In the above song the eating of the sweets has been associated with the covert sexual suggestion. The association of food with sex has been shown by G. Bose in his *Concept of Repression*. In the Garo Mythology known as Salgera, one of the Gods, came to the house of his niece telling her that he had come to have a talk with her. The niece was pleased and offered the maternal uncle some food. The uncle after eating his meal indulged in sexual intercourse with the niece. In Garo jokes also, asking one

to come to talk in privacy, or to offer betel and nut, to offer food to eat, all signify proposal for sexual intercourse.

M

Dobisāko wāsingo
Thék tā théknā,
Bātchumāko noksikchi
Sikbeknā,

(Push the chicken hard into the cavity of the bamboo pipe. Push the old woman to the corner of the house.)

The chicken and the tubular hollow of the bamboo are symbols representing the small penis and the vaginal canal respectively. The song here represents the childhood oedipus wish.

Nidofānā dosādilnā
Rimme khālnā ennodé
Miāsāni rishfelnā

(If you look up, you will see the moon in the sky. If you want to catch hold of something to play with there is the ball of the male.)

Here the moon is associated with the testicles.

F

Ālli jol jol bethgippā
Nāchi ongjā āngkhesā,
Onthé onthé jitbābo
Sokme khuthe nangesā

(What you see boring holes along the ridges of the field is not a fish but a crab, come gradually nearer to me so that my nipples may touch your body.)

In this song the woman invites the man to have sexual intercourse. But the unconcious attitude is peculiar. What the unconcious of the girl wants to convey to her lover is that her male partner need not be afraid of a sexual attack from a phallus. It is not the fish which is the symbolic penis, that will bore a hole, but the soft breasts will simply touch his body. The female is in the active attitude although the activity is hidden to some extent by the request to the male to approach her. Spiders, crabs & similar animals are feminine symbols. Psychoanalysis has shown that the spider is often symbolically associated with the vagina of the aggressive mother. So also crab, but here the aggressiveness has been rendered harmless and has been transferred to the

nipples of the breast. The nipples like the clitoris often represent the phallus in the unconscious.

Ābā chiring chikhólok
Jāsuobā thāl jājok,
Diāl thāngmong roobā
Nānkho nāngmā enbijok.

(In the pit in the corn field where water has accumulated I could not even fully dip my feet. Your mother rebuked you for roaming with your sweetheart.)

The symbol of dipping the feet, in the above song is clearly one of sexual intercourse. The song represents a resistance situation

M Selso hāni ākhingthe
Rikhim Rikhim gāmānjok,
Nomeldrāng khisāngthe
Thójāo thójao muktchājok.

(Walking on the mustard field a clod of earth under my feet I felt, oh, how I like the moving buttocks of the maids.)

Earth is the mother symbol. The clod of earth therefore may have a close symbolic relation with the buttocks of the mother. The song represents the oedipus wish.

M Sokā bajok sosengā,
Chāmisaha wālsengā.

(The leaves of the cane plant have been shed. The partners in love have past the night together.)

Here it seems the leaves of the cane plant stand for chastity or virginity. Leaves here may also symbolise clothes. I may refer to the symbolism of the fig leaf in this connection.

M Chiring rong the rongleng
Fileng fileng gāmanā
Angni mukcha gepākho
File file nimonā

(The stones on the bed of the streamlet are flat, they feel flat to my feet when I walk over them. I very much like to have my dear one by me.)

The sensation of touch, felt in the feet is odviously associated in the unconscious mind with the sensation of coitus.

From the examples I have cited, it will be clear that the first

two descriptive lines have some sort of emotional connection in the unconscious with the desire expressed in the last two lines of the poem. On enquiry from the Garos I have found that, they are not consciously aware of this relation. When I questioned the composers as to the reason of giving such description first and then speaking out the desire, they told me that the imageries contained in the first portion of the song, appear in their mind, spontaneously. They only speak out what they feel. The link between these two parts of the song is not known to them in the majority of cases. It may be said therefore that the imageries expressed in the songs of the Garos are motivated by the unconscious desire which usually comes out more clearly in the later part of the composition. It is interesting to note that in most cases the desire finds a freer expreseion in the last two lines than in the preceeding ones. This can be explained on the supposition that the unconscious material plays a trick on the censor and comes out into the conscious mind under the garb of an innocent symbolic expression and then once such admission is gained the more direct thought follows in its wake. This is a very common mechanism known to psycho-analysts. The unconscious desire striving for satisfaction, invents new forms of expression to escape from its captivity by one means or another. In the songs already mentioned you have seen how the oedipus and the forbidden hetero-sexual desires have found their entry into the conscious mind. I must mention here that I have not been able to trace any homosexual desire, active or passive, either in their stories or in their songs. In their mythology also there is no mention of homosexuality nor there is any expression of homosexualty in their art or craft motif. The Garos deny the practice of homosexual activity in their society. But I have sometimes seen a male catching hold of another's penis and at the same time having erection himself. I have noticed on two occassions that when during a friendly wrestling between two naked boys one of them fell on the ground face downwards, the other immediately got on the back of the prostrated boy and began to make a to-and-fro movement of his body, his erected penis being thrust between the buttocks of the latter.

One case of sexual activity between father and daughter was reported to me and was corroborated by others. In the following Re Re song reference of sexual relation between the father and the daughter is expressed,

M Hārongāni atongdi
Oātte fāla khokhāreng,
Bolmānjāro wālnikham
Nāngni fāde rāmkereng.

(The Atong people of the hills sell the buskets they make. Your father is reduced to skeleton. He can not have any strength for night activity (sexual).)

The singer here indirectly invites the girl to offer herself to him just as the Atong people offer the buskets to the purchasers. The father's incapacity for sexual intercourse with the daughter has been hinted at. I have quoted only a few of the Gonda songs from my collection numbering more than five hundred. I shall mention some of the symbolic expressions occuring in the first half of the song and their correlates in the second half.

F = Sung by females
M = Sung by males

F	Kite	Pante (male)
M	Crowing cock	Sexually excited male person.
M	Goat	Male person
F	Heron	„ „
F	To offer liquor	To propose sexual intercourse
F	Dog	Husband
M	Plantain tree	Penis
F	The Drum Stick	Penis
M	Fish	Penis
M	Clouds covering the moon ...	Spoiling female chestity
F	Sparrow	Young male person
F	White flower	Teeth
M	To eat sweets	To have sexual intercourse
F	Monkey	Male enticer
F	Pitcher	Womb or uterus
M	Chicken	Penis
	Bamboo tube	Vagina
M	Small dug out boat	Female genital
F	Moon	Testicles
M	Creeper	Woman

F	To offer a smoke	To have sexual intimacy
M	Crocodile	Male kidnapper
M	Flower	Woman
F	Fong (A variety of gourd with long neck) ...	Penis
F	To call one for conversation ...	To have sexual intercourse
M	Clod of earth	Buttocks of the woman
M	Peacock	Male lover
F	Cocoanut shell of a Hukka ..	Vagina or womb
M	Porcupine	Male sexual partner
F	Parrot	A male symbol
F	Hollow cavity in the trunk of a tree	Vagina
M	Female "Bulbul" (bird) ...	Mother
F	Orange tree	Female body
F	Red flower	Female face
F	'Baloon' fish	Female body
M	Barking deer	Male person of superior position
F	To cut a lemon with a knife ...	To pour liquor into the partner's mouth with a bowl having a long neck = To have sexual intercourse
M	Locks of long hair anointed with oil	Snake = Penis

Many of these correlations are also to be found in the dreams of the Garos.

From the standpoint of psycho-analysis the predominance of the oedipus wish in the Garo Gonda is noticable. I may mention here that in my paper on "An attempt at interpretation of a Garo dream" and "Dreams of the Garos" the same predominance of oedipus desire was noted.

In the Garo society most of the adult males have to marry their maternal aunts, when they become widows. Although this presents an opportunity for actual intercourse with a mother substitute, the original craving for intercourse with the mother, in the unconscious, remains fixed. The partial fulfilment of the oedipus wish with a mother substitute can not release the unconscious desire from its mooring of the early childhood days. This has been amply coroborated by the Gonda songs I have mentioned. The oedipus wish with its corrolary, the castration fear, have been found to be the unconscious motive force behind some of the Garo Gonda songs, mythological stories, dreams and art motives, It should be noted however, that no expression of homosexuality

could be traced in any of these branches of Garo life. Apart from the incidents I have mentioned I have not been able to find out any trace of homosexuality in the Garo society. It appears that the repression of this phase is very deep. Further investigations may throw light on this phase of the unconscious. It is not yet hundred years when the different Garo groups were fighting with one another and head hunting was in vogue. I have met some Garos who had indulged in head hunting in their younger days. Now this practice has been strictly forbidden by law under the threat of capital punishment. War mentality has a homosexual component. The Garos who were warring people a few years ago do not show any sign of homosexuality after their cessation of martial activities. When the Second Great war broke out many Garos expressed their willingness to join the army and many have actually done so. The desire of head hunting which is psycho-analytically a castration wish finds outlet in dreams, rituals and in songs. If in the case of the Garos the homosexual component of their sexual life has been successfully repressed their oedipus wish could not be subjected to the same degree of repression.

APPENDIX A

Examples of different varieties of Garo Songs

CHERA

Gandru joe joe
Oksthe repak repak
Gasa ringa
Bara thange
Gasa ringja
Bani Bani jillana
Gasa rigen

AHUMA

Chi khamachi iusa
Tisa rongthe rongaka
Ahuma hue Ahuma
Chisamoni wathe
Songmagri fanthe
Aha Ohuma hue Ahuma

AJIA

M Seng-chopko chopchopna
Anga jiko manjaode
Abisako khemona

(There it sounds "chop chop", if I do not find my wife I shall marry my elder sister.)

DANI

Sa Sa mani asonghi
Wanbol miako
Tru jangia waumа miara
hai anga Dani
Khasi jarot chokko
Maljaja khimansia
Bri abrio chimansa waldukha
Oho anga rada.

RE RE

Bargenengni majiao
Balsa bibal rimmeta
Mukrono neggija
Nangside hameta
Harara Harara

(Between the two flowers one flower is yellow, your husband blames you without seeing for himself.)

GONDA

F Thring thring bolgeppa
Selgasakni jonsene
Baju dengol enggode
Habuobo simsangchi

(The insects fly upwards high up in the sky ; if you feel the heat of the day, Darling, take your bath in the waters of the Someswari river.)

M Habreng sikhar khagipa
Tarun bahadur sachim
Bini fanthe mitingo
Nina nithob biachim

(Tarun Bahadur is the only man who can do the shikar in the forest of the hills. He was extremely beautiful in his younger days.)

SOME ASPECTS OF THE UNCONSCIOUS IN HYSTERIA

NAGENDRANATH DE, M.B., D.T.M., M.R.C.P., D.P.M.

Hysteria, though it often appears only at adolescence or a later period of life, never comes like a bolt from the blue. A careful study of the individual even before any of the manifestations of the disease is evident will reveal certain characters of which deficiency of repression is the main feature. As a result the mind of the hysteric, of whatever age he or she may be, retains many of the characters of childhood.

The teaching of modern civilised society is to cultivate altruism, to learn to consider the convenience and inconvenience of others, in many instances at the risk of some sacrifice on one's own part. Even a normal child takes some time to learn this. At the beginning of life the child is selfish to the bottom and remains practically the same to about the age of five. Up to that age the only consideration that a child may show is towards its younger brother or sister, but an analytical scrutiny will reveal that this consideration is not motivated by altruism but is often a product of imitation of the parents and the wish for domination; thus when a child offers a toy to a crying younger sibling it does not offer it relief but offers it a favour in order to win mastery over it. Any consideration for its superiors comes much later in life. The other day I saw a group of three children, whose mother was lying ill with headache. Being lulled to sleep by some one else, the eldest of the lot aged 4 years and 4 months said, 'Mother has got pain in her head; who will give us our feed of milk when we shall get up from our sleep?"

Hysterics are equally selfish at heart. The selfishness in their case is due to domination in the mind of the selfish unconscious and that is why they cannot realise their own weakness. A patient of mine, a woman of about 35, whose husband was earning only Rs. 80/- a month, would force him to spend at least half his income every month for the treatment of her hysterical symptoms,

so that they would have to live on Rs. 40/- only or less per month including expenses for food, dress, rent of house and pocket expenses. Not only that, she would not allow her husband to spend a pice for himself without her previous sanction. She would explain her behaviour on the ground that she was suffering from a serious disease and all the available resources must be utilised for her. She was suffering no doubt, and suffering for nearly 20 years, but was none the worse for it physically.

What becomes deeply burried in the unconscious in a normal individual remains more or less superficial in the hysteric, occupying a territory which would otherwise have been occupied by the conscious or preconscious part of the mind and thus prevents proper developmant of the faculties of the conscious mind. Hysterics are seldom deep thinkers. They take everything superficially. As in the case of chidren, everything new has a charm for them. They judge by first impression. Any interest they may show for anything is neither constant nor deep.

The inhibitory influence of the conscious and pre-conscious, which themselves have suffered defective development, on the unconscious, impregnated with emotions, is very limited in the hysteric and so emotions are easily aroused. Any humour, just sufficient to provoke a smile, will induce hillarious laughter in a hysteric. A trifling remark will bring forth an outburst of rage. But, like children's quarrel with playmates, the rage subsides rapidly and opportunity is sought to re-establish friendship. Such emotional outbursts at a minimal cause, when in the sex sphere my lead to trouble. The preponderance of hysteria among prostitutes is not because they are more liable to it but because many of the hysterics, as a result of their emotional instability in sex sphere fall into trouble and have ultimately to lead a life of shame.

The educable secondary system forms only a small portion of the mind of the hysteric, the far greater part being formed by the unconscious which is not amenable to reason and not capable of learning anything. This is why they do not develop a moral code of life consistent with the society in which they live. Their morality is shown by dependence on a particular person and by guiding their

behaviour by what that particular person would like. Chastity is not valued above pleasures of life. Discrimination between truth and falsehood is imperfect. Like little children, hysterics tell little lies without much motive or purpose except perhaps to cause a little row. Many of the stories told by adult hysterics about sexual assaults in early childhood are proved on investigation to be false.

Perceptions influenced by the unconscious become defective, resulting in the production of anaesthesia, blindness, deafness, anosmia, etc. and also perverted sensations, e. g., coldness, numbness, formication and some hallucinations, etc. Affects belonging to these unconscious factors are responsible for uncontrollable outbursts of emotion and inconsistensies of mood. Reversal of affect is found in the sadistic behaviour of some hysterics who find pleasures in inflicting pain on their most loved ones or teasing them almost to the limit of their tolerance. Incongruities of motor behaviour viz, involuntary movements, distortion of voluntary movements and functional paralysis, which are distinguished from organic ones in that they are purposive show that they are of unconscious psychic origin.

The comparative superficiality of the unconscious is responsible for its approachability. When a female patient who was complaining of paralysis of the left wrist and fingers alleged to have been produced by a cut in the left index finger at the junction of the middle and the terminal phalanges while mending a pencil five months ago, was asked to tell about herself, her work and her family, (it is my custom to put all these three questions together in order to see which points are stressed by the patient) she said "I am the first of the three children of my parents, the other two being a younger sister and a still younger brother. I am now 23 and have been working as a typist for the last seven years. My sister, two years and three months younger than myself, was also a typist but has been married last January (6 months previously) to an engineer drawing 550 pounds a year." Several points are worth noting in the statement of the patient. She did not tell anything about her parents, not even whether they were living or dead nor did she tell how much younger her brother was and what he was doing. But she gave the details about her sister as to exactly

how younger she was, what she had been doing, when exactly she was married and even the exact income of her husband. It is not difficult to detect in her statement the unconscious wish to be well placed in life by marriage like her sister and thus be relieved of the trouble of toiling for herself which she has been doing for the last seven years. The paralysis of the hand and wrist from a minor injury near the tip of a finger is unconsciously determined and is only an expression of "I do not like to work any longer." The irrationality of the means adopted shows its unconscious origin. Any consciously thinking person, even a malingerer, can easily realise that a paralysed hand will rather stand in the way of a desirable marriage than facilitate it. The cut in the finger, which was supposed to be the cause of the paralysis, occuring within a month after the marriage of her sister, was also, in all probability, unconsciously determined.

My reason for citing this case is to show how superficial the unconscious of the hysteric is with reference to certain symptoms and how it can be reached practically without much analysis. I found it still more superficial in another patient of mine, an elderly Englishman complaining of paralysis of right arm and both legs. When asked in the same fashion to tell about himself, his work and his family, he said "I am now 54, a barber by profession, I have spent the best part of my life in maintaining my wife, who has been ailing continually for the last five years, and a family of 9 children, the youngest of whom is now 17 and has joined work 3 months ago." In these words I could hear his unconscious which, if allowed to continue, would have said "And now that I have done so much for my family, I would like that I should retire and my family should take care of me." But there was the resistance : an Englishman cannot express his desire to depend on his children for his livelihood. So when I asked him "What do you propose to do now ?" He said "I would have been glad if I could continue like this but, as you see, it is impossible." Here also the expression "as you see" is used by the prompting of the unconscious to make it evident to the physician as also to himself and to everybody else that he cannot work any longer. The paralysis of the right hand is the symbolic expression of his wish to retire from his work as a

barber and the paralysis of the legs represents the thought "I cannot *stand* it any longer, now that even the youngest child is earning and my wife is ailing for the last 5 years."

The appearance of the unconscious on the surface and the consequent possibility of approaching it directly explains the increased suggestibility of the hysterics. A conscious mind even of low intelligence is too critical to accept the suggestions usually accepted by hysterics. In hypnosis the surface layer of conscious mind is removed or made inactive and approach is thus made to the unconscious, for it is the uncouscious that has no reason or logic, and is most suggestible. Increased suggestibility due to superficiality of the unconscious is such a prominent feature of hysteria that Babinski said that every hysterical symptom can be produced by and removed by suggestion.

This acceptance without criticism leads to believing even the most absurd statement. Hysterics, like children telling lies begin to believe in their own concocted stories. This when associated with an imaginative trend of mind, which is also present in many hysterics, leads to phantasy formation; one cannot indulge in phantasies if one is reminded at every step that what one is thinking is not true.

The unconscious in the hysteric, because it affects a large part of the surface of the mind, modifies the motor behaviour in a manner designed in a symbolic way to fulfil the unconscious wish but, being unconscious, it cannot keep touch with reality. It has therefore been said that a hysteric is merely an actor who has temporarily lost his head but goes on playing his part thinking it to be real.

Though the unconscious affects the surface to some extent in hysterics, it is not integrated with the remaining part of the conscious mind so that the two act somewhat independently of each other. This gives rise to the various dissociation phenomena which are so common in hysteria. Dissociations in the field of cognition and conation have already been described. Dissociation in the field of reasoning and judgment is responsible for disproportionately greater suffering undertaken for an advantage of much less value. Dissociation in the field of memory is responsible for

attacks of amnesia covering certain periods. Greater dissociation will account for phenomena like automatic activities, trances, spirit possessions, fugues, somnambulism and multiple personality.

It needs be mentioned in conclusion that the unconscious in all cases of hysteria does not conform to the above description. Just as it has been said of hysteria that there is no disease on earth which hysteria cannot simulate, so it can be said with equal amount of truth that there is no conceivable form in which the unconscious in hysteria cannot present itself. What is depicted in this paper is a picture of those cases where repression is at a minimum, and many of the unconscious wishes remain superficial, and apparent even without analysis. It is because of the superficiality and visibility of the unconscious wishes in these cases that hysteria has gained the ill fame of being almost equivalent to malingering. There are other cases again in which we find that the repression is extreme and the unconscious motivations, far from being apparent, are distorted almost beyond recognition.

PROFESSOR FREUD : THE BEGINNING OF A CASE HISTORY

PAUL FEDERN, M.D.

Dr. Federn writes, "When I saw Freud the last time in Vienna he presented me with the minutes of the Vienna Psycho-analytical Society. These minutes are of great historical value because in the terminating discussion the Professor frequently announced some of his new discoveries. Until now these minutes could not be published. But they do not lose their value. I have translated and edited a few of these minutes. I enclose one of the most interesting thinking that you might perhaps be pleased to be the first with beginning this publication."

On October 30 and November 16, 1907 Freud referred for the first time to a part of the case of obsessional neurosis which he later presented at the First Psycho-analytic Congress in Salzburg in the form in which it was published. It became famous as the story of the "Rattenmann"; every psycho-analyst and every psychiatrist interested in Freud's method may be expected to have read it.

It is neither necessary nor possible to relate the entire case here; the minutes of the session, however, are interesting to us because of Freud's concluding answers to the discussion and because of a few of his sentences in the presentation itself. The minutes are very reliable, since they were taken by Otto Rank; this eminent young scholar was at the time absolutely devoted to Freud, who favoured him in every way.

The minutes start with a very short abstract of the case. It is a very instructive case of obsessional neurosis (obsessional thinking), the case of a young man of 29. His sickness dates from 1903, but actually it started already when he was a child.

He is harrassed by obsessional fears that 'something' might be expected to happen to two persons he loves very much. Freud stresses that "expressing thoughts so vaguely and avoiding to tell facts in this manner is characteristic of the obsessional neurosis."

These two persons are the patient's father and a lady whom he loves and admires.

He had abstained from sexual intercourse for a very long time

and indulged very little in masturbation. He had his first intercourse at 26.

Here followed a detailed presentation of the analysis in the first few sessions. The minutes omit this and quote only a few of Freud's statements :

"The technique of psycho-analysis has changed. Nowadays the analyst no longer goes in search of that material which is interesting to him, but he leaves the patient to develop his ideas and thoughts in their natural course."[1]

The basic conflict lies, roughly speaking, in the patient's wavering between his drive towards man and that towards woman. Unconsciously his drive urged him more towards man.

There were repressed death wishes against the father; obsessional ideas are practically always wishes of obsessional strength. This case shows with special clarity features which are present in every case of obsessional neurosis.

The essential contents of this type of neurosis consist in bad and aggressive, hostile, cruel feelings and sadistic murderous wishes;[2] this is especially obvious in the present case. This cruel component can rightly be called masculine ; yet this masculine component is equally present in women. The fact that the relationship of unconscious sexuality to neurosis is the same in man as in woman allows the following theoretical conclusions :—

The Unconscious in man is basically not different from the Unconscious in woman.[3] Neurosis always develops at the expense of active drives which are repressed.[4]

1. This remark is of historical interest, as it was made in 1907.

2. As far as such patients are aware of these feelings and wishes they fight them consciously

3. This remark was directed against a general concept of Rank's, namely that the Unconscious in man is his femininity and the Unconscious in woman is her masculinity.

4 In later years Freud changed this point of view, recognizing that repressed masochistic tendencies also play an important part in neurosis. Yet, since one source of masochism is always sadism turned into its opposite, another femininity, and a third one a biological connection between pain and sexuality, the change of opinion is only a partial one.

The following members of the Society took part in the discussion : Rank, Stekel, Sadger, Hitschmann, Schwerdtner, Federn, Graf, Adler, Steiner.

Rank—Rank expressed his conviction that this case history allows the assumption of a very strong love tie between the patient and his mother, although there has not yet been any direct confirmation of this statement in the analytical material. In the child the struggle between the drives towards man and that towards woman in general is condensed into a struggle between the love towards the father and that towards the mother.

Stekel—Homosexuality does not only occur as a complication of obsessional neurosis, it is also present in all cases based on 'incest.' Homosexual inclinations are to be found not only in the unequivocal analytical material, they are also proven by the fact that the patient's conscious phantasies identify his father with the beloved lady. His phantasy has them both tortured at the anus. This shows that in his phantasy the patient uses the woman just as he would use a man ; therefore both are identically treated.

"The most essential thing is that the patient trust the treatment and the physician. The analyst should avoid by all means to standardize his work, as not every case is like the one presented. It is necessary to consider all individual and specific features in every single case."

As an example Stekel mentions one of his own cases, in which the patient remembers that the father, after having beaten the children, had forced them to urinate in his presence.[5]

Stekel in his analyses uses the technique not to uncover the deepest reasons and chains of causality before the patient has become quite devoted to and dependent on him. In the case just presented he believes, thereby contradicting Rank, that the patient has probably seen in his father a rival with the governess not with the mother.

Sadger—Sadger puts the question whether there were mainly homo-sexual reasons for the patient's compulsion in mailing his small debt.[6]

5. This case was reported in detail in another session, a few weeks later.
6. The analysis of this compulsion fills many pages in Freud's paper.

Sadger replies to one of Stekel's statements (that some patients want at all events to be hypnotized) that this is the case only in homo-sexual and in very masochistic patients.

Hitschmann—Hitschmann shows the prominent role played by miserliness in the symptom just discussed by Sadger. He doubts that the patient is proven to be homo-sexual. He for himself explains the obsessional neurosis in the following way: already in early days a mechanism of obsessional thinking develops in a patient of this type; this mechanism is later on activated by traumatic events; other children might also have to experience similar traumatic events, without however becoming obsessional. Hitschmann therefore thinks that the combination of both factors, obsessional thinking and traumatic events, produces the obsessional neurosis.

Schwerdtner—Schwerdtner asks two questions: 1. Why is it that in some cases the sadistic drive is repressed either unsuccessfully or with little success, while in another it could be sublimated? 2. Why do we wish to have unified feelings without any ambivalence only towards very near and dear persons?

Federn—Federn asks whether we have the right to call cruelty really a specifically male quality. He furthermore thinks that the single event is not traumatic on account of its immediate importance, but that every single event creates a chronic impairment and that these impairments accumulate into a lasting trauma.

Graf—Max Graf joins Schwerdtner in his wish to know why repression is successful in one person and unsuceessful in another.

Adler—Adler, as usual, speaks about technique. He is doubtful as to whether it is at all possible to teach or even to learn psycho-analysis. In many cases some things have to be left unexplained. It is important to take some of the enemy's positions, because their surrender warrants victory; it is not necessary, however, to slay all the enemies to the last man.[7]

Adler is not of Stekel's opinion, but thinks that we must not withhold from the patient the important threads of causality which

7. At the time this was said, in 1907, the terminology of war and fight did not present itself as readily to the mind as nowadays. These remarks therefore bear special individual-psychological earmarks.

are uncovered in the analytical material. The rules Stekel is laying down do not belong to psycho-analysis, but are 'psychodiplomacy.'

As for the present case, Adler is sure that it will be possible to find organic conditions in it. It is a case of very strong auro-eroticism which has not yet been substituted by hetero-sexual object erotism. Miserliness is also derived from auto-erotic drives and has its origin in the anal zone.

Adler is sure that there are more ways than one in psycho-analysis.

Steiner—Steiner is interested again and again in the fact that also other children have to go through experiences similar to those of the severe cases. In his opinion hate against the parents orIginates in the punishments, especially those during the cleanliness training. In order to explain why some persons become ill and some don't we have to assume a certain disposition, a sort of inferiority, but not in Adler's sense. Steiner does not think that cruelty is a specifically male quality—women are just as cruel as men.[8] Every neurotic man has some feminine qnalities.

Freud—Freud answered the speakers in the order in which they had spoken. He agreed to the criticism Adler had exercised on Stekel. As to the case mentioned by Stekel, the patient's story looks very much like a child's phantasy.[9] By no means does the material explain the neurosis. Since the the reported 'experience' is so clearly remembered by the patient, the problem remains what else forms the repressed Unconscious and thereby creates the neurosis.

Freud's patient had death wishes against his father even before

8. This remark is a forerunner of the opinion that cruelty as well as destruction belong to a separate drive, which is not different in men and women. Later on Freud developed this theory into a duality of drives: Eros and Thanatos.

9. At that time Freud knew already that mere phantasies also act in a pathogenetic way, although not to the same extent as actual ttaumata. For this reason Freud sometimes used witnesses and diaries in order to ascertain whether the analytical material he found consisted in phantasies of the patient or in actual experiences. When he finally found that phantasies which could not possibly have been experienced determined the neurosis of the patient, in general as well as in single symptom, he concluded that there must be some typical inherited phantasies present in everybody, which are later transformed into memories of assumed actual experiences.

his eighth year. It was therefore interesting to find out whether at that time or sooner someone in the patient's family had died. And indeed, when the patient was 3½ or 4 years old his sister, who was 3 or 4 years his senior, had died. The patient's earliest childhood memories are that his sick sister had been put to bed, that he had run to his father to ask what had happened, that his mother had cried and that the father had leaned over her. It was on this sister that the patient had noticed the sex difference when he was about three years old.

Hitschmann's theory of the obsessional neurosis is an arbitrary one. A "special disposition" is too easy an assumption—the actual conditions are much more complicated. The patient's miserliness, even though it certainly does play a role in the patient's neurosis, is not of primary importance. Formerly the patient had been extravagant and generous.

As to the question put by Schwerdtner as well as by Graf, why in some cases repression is unsuccessful and leads to severe neurosis while in others it succeeds and the pathogenic drive is sublimated: these questions are due to some extent to the speakers' disappointment in the achievements of psycho-analysis. This disappointment is unfounded, because we have no right to assume that there are specific differences between the normal and the sick. There is no such difference and by no means is there any difference of quality. 116225

In the neurotic, the premature activity period is followed by contrasting periods of complete repression of activity.

In general a human being cannot bear opposed extremes in juxtaposition, be they in his personality or in his reactions. It is this endeavour for unification which we call character. In regard to persons near to us extremely opposed emotions become so affective that they become completely unbearable.

In persons who are to stay normal we would not find as strong a feeling of hate against the father as in our case. In the present case we can explain this hate, because the father actually checked the very strong sexuality of the child.

It seems that Rank's opinion that incestuous wishes towards the mother are of etiological importance, will prove to be right in

the end. The present case, however, is complicated, because the patient had four sisters, two older than himself and two younger.

Federn is right in stressing that the patient showed hetero-sexual inclinations already in his very early youth and that his later homo-sexuality is in strong contraposition to this. I (Freud) have analyzed three overtly homo-sexual men, who actually transgressed the law. All three cases revealed a very early, very strong relationship to woman, that is, to the mother; later on this relationship was suppressed. On the other hand all ladies' men and ladykillers were in their youth more inclined to homo-sexuality.

As to Federn's other question: up to now it seems to be a question of agreement which qualities should be called male and which female. In no case is it permissible to classify some one as homo-sexual or hetero-sexual because his object is of the same or of the other sex.[10]

As to Adler, it should not be doubted that the psycho-analytic method can be learned. It will be possible to learn it successfully and safely as soon as the arbitrary technique of the individual psycho-analyst is restricted by proven rules. It is true that for the purpose of therapy some times a part solution of the patient's inner conflicts is sufficient; this, however, does not comply with the theoretical requirements nor does it reach the theoretically possible limit of analysis. In many cases, however, it is necessary for the sake of the cure to conduct the analysis until the end.[11]

Freud does not agree with Steiner when he underrates extrogeneous factors, as compared with constitutional ones.

The neurotics turn their activity into passivity. This explains why it is justified to call the neurotic man feminine.

10. With this remark Freud stresses the importance of subject homo-sexuality and rejects object homo-sexuality. Later on he adopted, as far as I know, Ferenczi's opinion, namely that both kinds of homo-sexuality exist. Even so, however, Freud stuck to the opinion that the quality of the drive is the important factor, while the choice of the object is dependent on childhood experiences, resistances, and shiftings.

11. On various occasions Freud rebuked the ideal of the short analysis. He once said that analysis renounced to cure "Cito, tuto et iucunde." Yet, for practical reasons he accepted it, especially when there was one main symptom of which the patient needed to be cured, as for instance in many cases of psychic impotance.

MEMORANDUM ON THE PROBLEMS OF PREVENTION AND TREATMENT OF MENTAL DISORDERS SUBMITTED TO THE MEDICAL RELIEF ADVISORY COMMITTEE OF THE HEALTH SURVEY AND DEVELOPMENT COMMITTEE, GOVERNMENT OF INDIA*

G. BOSE

The problems connected with mental disease are to be tackled by the community or the State exactly in the same way as those arising out of physical illness. Thus, there should be an effort to *prevent* mental disease on the one hand and on the other facilities should be provided for the proper *treatment* of persons suffering from mental disorders.

* In October 1943 the Government of India appointed a Committee called the Health Survey and Development Committee for a broad survey of the position in regard to health conditions and health organisation in British India and for recommendations for future developments. Government felt that time had come to make plans for post-war developments in the health field and that such plans should be based on a comprehensive review of the health problem. A list of subjects to be considered was prepared in detail and copies were circulated to Provincial Governments with a request for comments and suggestions. Questionnaire were drawn up and were sent to the Heads of Medical Departments in the provinces, the principals of Medical Colleges, Superintendents of Hospitals, Public Health Authorities, Medical Associations and to a number of individual medical men and social workers. The Health Survey and Development Committee appointed a Sub-Committee consisting of Dr. G. Bose, Dr. M. V. Govindswamy, Lt.-Col. M. Taylor, Dr. K. R. Masani, Lt.-Col. B. J. Shah and Col. A. H. Shaikh for considering the whole problem of mental disorder. This Sub-Committee was called the Mental Hygiene Sub-Committee and it held its first meeting on the 31st March 1944. The Mental Hygiene Sub-Committee submitted its recommendations to the main Committee and after due consideration the main Committee formulated its recommendations. As these recommendations are of extreme importance from the standpoint of future mental health in India, we print below extracts from the Committee's report. We are deeply grateful to the Government of India for giving us permission to print Dr. G. Bose's memorandum as also other extracts from the report of the Committee in our Journal.—Editor.

NEGLECT AND IGNORANCE

Unfortunately no systematic effort has yet been made in India to control mental disorders. For instance, in the whole province of Bengal although there are well-equipped establishments for the treatment of general diseases and also special institutions for tubercular, obstetric, opthalmic and other cases there is no adequate provision for the proper treatment of mental patients. The little that has been done in this direction has been mentioned later. Reliable data regarding the number of mental patients amongst the general population are not available but there is no doubt that the percentage of incidence is fairly high, probably as high as that in western countries. The milder types of mental disorders are not even recognised by the average medical practitioner. The training that the student gets for his Graduate course in Medicine is one-sided. Mental disease receives very scant attention and there is no provision for imparting any training to the medical student in the practical aspects of mental disorder. Mental deficiency is seldom, if ever, differentiated from thyroid deficiency by the general practitioner, and it is not uncommon to find obvious cases of primary mental deficiency being mistaken for cretinism and treated by thyroid by very eminent physicians. This will serve to indicate the colossal ignorance that exists at present amongst medical men in the field of psychiatry. Psycho-neurotic patients are often taken for cranks and eccentrics and no effort is made to give them any relief.

The general public as well as the medical profession has thus to be educated so that any manifestation of mental disorder may be recognised at its inception and steps may be taken for its cure. At the present time early mental cases seldom come for treatment. The patient himself and his relations are often unaware that the patient's troubles are due to disease and may be cured by proper treatment. It has been the considered opinion of a group of psychiatrists that the root cause of mental disorders is to be sought for in the early childhood days and that the family and the social environments play an important role in the genesis of mental disorders. The problem, therefore, is as much social as medical. In order that mental disease may be prevented it is necessary that parents and

teachers should know some of the fundamental principles of mental hygiene. There should be some sort of provision for imparting knowledge of mental hygiene to parents, teachers and others.

As the situation stands at present in India the entire problem of mental disorders has to be faced from two different angles viz, (1) making provision for institutions for the prevention and treatment of mental disorders and (2) the training of suitable personnel for such institutions.

PREVENTIVE MEASURES

The following list gives an indication of the diffierent types of institutions that are necssary for the prevention of mental disorder in its different aspects :

1. **Mental Hygiene Societies** for the spread of knowledge of mental disorders among members of the general public. These societies are best managed by private authorities. Propaganda activities should be entrusted to them.

2. **Home and Schools for Problem Children.** Abnormal behaviour in childhood is often the precursor of later mental disease. It is desirable to segregate problem children as distinguished from mentally deficient students from schools and from their homes so that they may be placed under charge of competent psychologists and psychiatrists who should be in a position to investigate the cause of their troubles and to advise remedial measures. Besides psychologists and psychiatrists such institutions should have in their staff social workers who should investigate the home conditions of the inmates and maintain contact between the authorities of the institution on the one hand and the parents or guardians on the other.

3. **Schools and Educational Institutions** meant for normal children should have in their staff psychologists and psychiatrists whose duties should be to find out the mentally deficient students from among the scholars and to advise their removal to special institutions. The problem of nervous manifestation in otherwise normal children should also be tackled by these authorities.

CURATIVE MEASURES

Coming to the curative side of mental disorder we have to make provisions for the following types institutions :

1. **Child Guidance Clinics.** Mental imbalance in any form in children is best attended to in these clinics. It will be the duty of the authorities concerned to recommend special training or treatment to mentally deficient children, problem children, neurotic children and other types of abnormal children coming to the clinic.

2. **Homes and Schools for Mentally Deficient Children** with the requisite staff of specially trained teachers, psychologists, psychiatrists, etc. The care and education of mental defectives, e.g., the blind and the deaf-mute should be the concern of the education authorities.

3. **Outdoor Psychiatric and Psychological Clinics** for giving advice to and for treatment of adult patients.

4, **Hospitals for Mental Patients**—mainly psychotics, drug addicts and sexual perverts.

5. **Psycho-analytical Clinics** for the treatment of special types of mental patients, e g., psycho-neurotics, problem children, etc.

6. **Special Mental Wards** in general hospitals.

7. **Mental Homes** for the housing of incurable indigent mental patients, street lunatics, etc.

TRAINING OF PERSONNEL

To deal efficiently with the different problems arising out of a mental health project like that under consideration the special personnel should consist of (1) the psychiatrist (2) the psycho-analyst (3) the occupation and diversion therapeutist (4) the social psychologist (5) the psychologist with special knowledge of applied psychology in its different aspects (6) mental nurses (7) mental attendants and (8) trained teachers for mentally deficient children.

1. **Psychiatrists.** More attention should be paid than is done at present to impart psychiatric training to students of general medicine. The special training of psychiatrists as in the case of surgical and medical specialists should be entrusted to the University authorities of the different provinces. It will be possible with a little State encouragement for many of the Universities in India

with a medical faculty to start diploma courses in Psychological Medicine. Post-graduate medical students attending such diploma courses should have facilities offered to them by the existing mental hospitals and clinics to study cases. At the present time there is a demand for stiffening the D.P.M. curriculum in the British Universities. The experience of the present war has shown that psychiatrists should have a much wider and more thorough training than they receive at present. I am of opinion that there should be two grades of psychiatrists in India, one corresponding to the diploma holders in psychological medicine of the British Universities and the other of a much higher grade for whom a longer period of study and a special curriculum have to be framed by the Universities. The latter group of srudents may receive some degree like the Doctorate in Psychological Medicine after passing their examination.

2. **Psycho-Analysts.** It is essential that students of psychiatry should have some knowledge of psycho-analysis. The only institution in India where practical psycho-analytical training is given at present is the Indian Psycho-analytical Institute managed by the Indian Psycho-analytical Society which is a branch of the International Psycho-analytical Association. Psycho-analytical training in the different countries of the world is controlled by this Association.

3. **Occupation and Diversion Therapeutists.** The training in occupational and diversion therapy can best be undertaken by the mental hospital authorities. The candidate must have special instructions in the different arts and crafts in suitable institutions and must acquire practical knowledge in them.

4. **Social Psychologists or Psychiatric Social Workers.** The training of such workers may be undertaken by institutions like Sir Dorabji Tata Graduate School of Sociology in Bombay. There should be similar institutions in other provinces.*

5. **Psychologists.** Psychologists with a special knowledge of mental testing, vocational and selection tests and of applied

* Since this Memorandum was written the Applied Section of the Department of Psychology, Univesity of Calcutta has introduced a Certificate Course in Applied Psychology with three Proficiency Groups viz. (i) Vocational and Industrial Psychology, (ii) Social Psychology including Social Psychiatry and (iii) Education of Defectives and Mental Deficients.

psychology in its various aspects, including industrial and clinical psychology, can be trained at the Universities. The University of Calcutta affords such training to their students taking up Psychology in their Master's Degree course with Industrial and Vocational and Advanced Abnormal Psychology as special subjects.

6. Mental Nurses. The training of mental nurses both in its theoretical and practical aspects may be undertaken by the mental hospital authorities. A special provision should be made for imparting the necessary theoretical side of the training to the nurses. The course of training for the nurses should be prescribed by Government in consultation with psychiatrists and superintendents of mental hospitals. There should be periodical examinations for granting certificates to mental nurses. Arrangements may also be made for imparting a training of a type superior to that given to ordinary mental nurses to specially selected persons who should function as staff nurses, sisters and matrons. There should be provision for employment of both male and female nurses for mental patients.

7. Attendants. There should be some sort of training also for ordinary attendants and menial staff in mental hospitals. This training can best be undertaken by the mental institutions themselves. Certificates may be awarded after completion of such training according to an approved course.

8. Teachers For Mental Deficients. The special class of teachers in charge of educational institutions for mental deficients should be recruited from the ranks of B.T.'s and of M.A. and M. Sc's in Psychology. These teachers should attend a special course of instructions in mental deficiency and allied problems. A diploma may be granted for such training. It is desirable that officers in charge of Borstals, Reformatory Schools, Juvenille Courts and similar institutions should also receive such training which may be in charge of the University authorities.

TRAINING CENTRES

It is essential that the training centres for the different types of personnel, such as the psychiatrists, psychologists, nurses, social workers etc. should be distributed all over India and should not

be concentrated at any one centre. The personnel described in this memorandum will be found to be quite adequate to serve the needs of all the different types of mental institutions. Refresher courses should also be arranged for the benefit of psychiatrists and and others.

ADMINISTRATION

There should be a Central Board of Mental Health under the Government of India consisting of Government representatives and outside psychiatrists, psychologists and educationists. There should be a Director of Mental Health who should work under this Board. As already mentioned before the Director of the Board should not be directly concerned with any training of the mental personnel. The University authorities of the different provinces should organize suitable courses in psychiatry, psychology, etc. and should be responsible for the award of certificates, diplomas, degrees, etc. in mental disease, etc. The general medical and surgical curricula are at present devised independently of State control. The mental health curricula should similarly be framed by the University authorities. The Board of Mental Health should of course insist that the minimum requirements are fulfilled before any Government sanction is given to these courses. The training of nurses and social workers also should be left to outside agencies who should be required to fulfil the essential requirements for such training. The periodical inspection by the Director of Mental Health of the different centres concerned in the training of mental health personnel is desirable. In general the supervision and control should be of the type as exists in the case of medical and surgical courses at present.

To give effects to the scheme of mental health it will be necessary to establish different types of mental institutions in the different provinces of India. The existing private mental institutions, however imperfect they may be, should be given encouragement and State aid to develop on proper lines. There should be a few institutions under the direct control of the State also. Thus there should be State-managed mental institutions as well as State-aided private institutions under the scheme. Where State aid is granted

to any institution Government may have a representative on the managing board of the institution. If audited accounts are demanded every year and if there be periodical inspection by some such authority as the Director of Mental Health there need be no apprehension regarding the misuse of grants. Some sort of liaison officer to maintain contact among the different mental institutions, general hospitals, public health bodies and educational centres is desirable to maintain their efficient functioning. Research in mental disease and allied mental problems should be encouraged by Government grants and stipends. Such research should be conducted in the different mental institutions which should be provided with suitable facilities.

It has been the general practice hitherto to appoint psychiatrists as superintendents of mental hospitals. In my opinion a good deal of the superintendent psychiatrist's valuable time and energy, which could be much better employed in his own line, is spent in purely administrative work and in the general management of the hospital. The post of the administrative superintendent should be separated from that of the technical psychiatrist who may not possess the necessary qualifications for the difficult art of management of institutions. This division of labour does not imply any dual control because the spheres of activity of the psychiatrist and the general superintendent are entirely different. It will of the duty of the superintendent to attend to all the directions of the psychiatrist in all matters concerning the treatment and management of patients. The psychiatrist will thus be left to utilize his special abilities in the greatest measure possible for the benefit of the institution. In case of any difference of opinion arising regarding the expenditure on any item or on anything else the question may be settled by the board of management of the institution. The general superintendent will be responsible for maintaining proper accounts and for the allotment of duties of the different members of the hospital staff according to the requirements indicated by the psychiatrist. The office administration should be in the hands of the superintendent.

EXISTING MENTAL INSTITUTIONS IN BENGAL

The only institution where indoor mental patients may receive scientific treatment in Bengal under specialists is the little paying hospital named Lumbini Park situated in a suburb of Calcutta. This hospital is managed by Indian Psycho-analytical Society. The Society is registered under Act XXI of 1860 and the hospital under it is not conducted for any private gain. There is accomodation only for 40 patients at present. Lumbini Park has an attached outdoor clinic where mental patients are attended to free of charge. There is another outdoor mental clinic at the Carmichael Medical College, Calcutta, managed by the Indian Association for Mental Hygiene. Although the parent association is now practically extinct the clinic continues to function. Very recently two other outdoor psychiatry clinics have been started in Calcutta, one at the Calcutta Medical College and the other at the Sambhunath Pandit Hospital.

There is a private managed institution called Mental Hospital with its central office in Calcutta and its indoor hospital at Mankundu about 19 miles from Calcutta. This hospital receives grants from the Calcutta Corporation and from the Bengal Government. It has accommodation for about 100* patients.

Besides the above there are two private institutions for the treatment of mental patients along indigenous *ayurvedic* lines. The total accommodation is adequate for about 30 patients.

The Government of Bengal maintains a ward at Calcutta for mental patients for the purpose of medico-legal observation. The patients are ultimately sent to the European and Indian Mental Hospitals at Ranchi from this ward.

There are two homes for mentally deficient children in Bengal viz., one at Kurseong, D. H. Ry., for European and Anglo-Indian children and the other at Jhargram, Midnapur, Bengal for Indian boys and girls. The Kurseong institution receives grants from several provincial governments. It can accommodate about 20 scholars. The Jhargram institution receives a grant from the Bengal Government. It can accommodate 50 children.

* This information is not based on official source.

FACILITIES EXISTING IN BENGAL FOR THE TRAININC OF DIFFERENT MENTAL PERSONNEL

1. **Mental Hygiene**
   (a) School Hygiene course for Matriculation students.
   (b) Teachers Training Department, University of Calcutta.
   (c) All-India Institute of Public Health for D.P.H. students.
   (d) Calcutta University M.A. and M.Sc. course in Psychology.

2. **Psychiatry**
   (a) Calcutta University M.A. and M.Sc. course in Psychology with Advanced Abnormal Psychology as a special paper. The training is confined mainly to the psychological side of mental disorders.
   (b) Out-door Clinics
      (i) Lumbini Patk
      (ii) Carmichael Medical College Psychological Clinic.

   Instructions in psychiatry are given to under-graduate and post-graduate students of medicine and also to post-graduate psychology students. Lumbini Park Indoor Hospital affords facilities to bonafide students to study mental cases either for training or for research.

3. **Psycho-Analysis**
   (a) Indian Psycho-analytical Institute affiliated to the International Psycho-analytical Association trains suitable candidates, both in theoretical and in practical psycho-analysis.
   (d) Calcutta University M.A. and M.Sc. course in Psychology affords training in psycho-analysis in its theoretical aspect mainly.

4. **Occupation and Diversion Therapy**

   Lumbini Park. A course of lectures is given in this subject for the benefit of the staff mainly.

5. **Social Psychology**
   (a) M.A and M.Sc. course of the Calcutta University in

Psychology with Social Psychology as special paper. Teaching is confined mainly to the theoretical side.

(b) Labour Welfare Officer Training Scheme—Calcutta University. There is a provision for training both in theoretical and practical aspects of Social Psychology.

6. Psychology with Special Referance to Applied Psychology, Industrial Psychology, Mental Testing, Vocational Guidance, Etc.

The Calcutta University Psychology course in M.A. and M.Sc. with Industrial and Vocational Psychology as a special paper affords ample opportunities both for theoretical and practical training in these subjects. The Department of Psychology has an Applied Psychology Section attached to it.

7. Mental Nursing

Training is given to nurses and attendants of Lumbini Park by a special course of lectures.

8. Education of Mental Deficients

Theoretical training is given to students attending M.A. and M.Sc. course in Psychology—Calcutta University.

STATISTICS

The figures in the following tables have been taken from the Census Report of 1931 and Statistical Abstract for British India 1942. According to the Census Report the rate of incidence of mental disorders in India is on the increase. The number of mental patients is largest in Bengal. Of 22402 patients in Bengal 13046 are males and 9356 are females. There is reason to suppose that the entry under mental disorder in the census table is much too low. The rise in the incidence of mental disorders noted in census reports seems to be more apparent than real and may be explainable as due to progressively better recording of cases. The records of incidence of mental disease obtainable from foreign countries do not show much wide variation from year to year and there is no reason to suppose that conditions are significantly different in India in this respect.

Incidence of Mental Disorder in India (1931 census)

India	21,8753 persons	i. e. 34 in 100,000
Bengal including Bengal States	2,2402 „	„ „ 44 „ „ „ „

Population of India (1941 census)

	Males	Females	Total
India	201,025,726	187,972,229	388,997,955
Bengal	31,747,395	28,559,130	60,306,525

Insane Population according to All-India Census Report 1931

(*Statistical Abstract for British India* 1942)

Administrations	Males	Females	Total
Madras	8,957	6,437	15,394
Bombay & Sind (with Aden)	7,065	3,846	10,911
Bengal	12,650	9,055	21,705
United Provinces	7,432	3,787	11,219
Punjab	4,853	2,367	7,220
Burmah	7,373	5,529	12,902
Behar & Orissa	5,416	2,848	8,264
Central Provinces & Behar	2,844	1,682	4,526
Assam	2,929	2,108	5,037
North West Frontier Province	543	198	741
Beluchistan	138	48	186
Ajmere-Merware	145	72	217
Coorg	13	18	31
Delhi	60	29	89
Andamans	6	1	7
Total—Provinces	60,424	38,025	98,449
... —States	74,002	46,302	120,304
Total—India	134,426	84,327	218,753

Mental Institutions (Census 1931)

Province	Number of Institutions
Assam	1
Bihar & Orissa	2
United Provinces	3
Central Provinces	1
Punjab	1
Bombay	5
Madras	3
Burmah	2
Bengal	0
Total—India	18

Population of Mental Hospitals, 1939

(*Statistical Abstract for British India 1942*)

Province	Males	Females	Total
Madras	2,236	684	2,920
Bombay	2,321	1,069	3,390
Sind	290	53	343
United Provinces	1,190	360	1,550
Punjab	1,055	244	1,299
Bihar	1,320	461	1,781
Central Provinces	494	119	613
Assam	644	140	784
Total (1939)	9,550	3,130	12,680

Government Expenditure on Mental Institutions

Total Expenditure	Rs. 31,66,211
„ Receipts	7,98,037
Net cost to Government	23,68,174

EXTRACTS FROM THE RECOMMENDATIONS OF THE BHORE HEALTH SURVEY AND DEVELOPMENT COMMITTEE, GOVERNMENT OF INDIA

Introduction

1. The physical and mental health of an individual are inter-related and no health programme can be considered complete without adequate provision for the treatment of mental ill-health and for the promotion of positive mental health. Positive mental health is characterised by discriminative self-restraint associated with consideration for others. A man in such positive health uses effectively his intelligence and talents to obtain the maximum satisfaction from life, with the minimum of discomfort to others. He will not allow himself to be overwhelmed by the stresses and strains inseparable from ordinary existence. He not only profits from experience but under favourable circumstances, can transcend such experience. It should be the aim of every health programme to include measures meant to assist the individual to achieve mental stability and poise and develop into a useful citizen.

2. Conditions of mental ill-health may be divided into two broad groups, (i) mental disorder and (ii) mental deficiency.

Mental disorder may be either inherited or acquired, and very often it is both. No age is exempt from mental disorder although the types may be different at different age periods. A large proportion of them is amenable to modern methods of treatment.

Mental deficiency is ascribed, on the other hand, to a hereditary or congenital taint or to some accident or iilness occuring just before or soon after birth. There are grades of mental deficiency, and although the condition is generally regarded as incurable, yet by proper care and supervision, the majority of defectives can be made to lead useful but segregated lives; and what is more important from the point of view of society, they can be prevented from becoming criminals and in the case of girls, social menaces.

3. It may be of advantage, at this stage, to examine such evidence as is available regarding the incidence of these conditions elsewhere and attempt to draw from it inferences applicable in this country.

In England and Wales there were at the beginning of 1937 about 129, 750 patients under treatment in the mental hospitals maintained by the various local authorities, who are responsible, under the law, for making such provision. This figure gives a proportion of about 3·2 mental patients per 1,000 of the population.

In Ametica, the annual admission rate is more than 170,000 to the public mental hospitals, in which is already resident a population of half a million patients. More hospital beds are devoted to the care of the mentally sick than to the treatment of all other patients combined. In some States, as much as one-eighth of the revenue is earmarked for expenditure on the mentally sick. There are 500,000 mental defectives, and perhaps as many epileptics. Amongst criminals, there is a very large number whose offences are attributable to diseases and defects of the mind and maladjusted personalities.

During the World War, one-sixth of all casualties were neuro-psychiatric, excluding wounds, and a peak load of one-third or more was sometime reached by such causes. At least one child out of every twenty-seven children born in America and one in thirty born in England is likely to become, in the course of a few years, mentally sick to such an extent as to requre admission in public hospitals. This is an appalling figure, but it does not include large groups of persons in whom the essential basis of ill-health is either a defective personality or an inability to adjusts themselves to a difficult environment, while they are diagnosed as cases of debility, gastritis, anaemia or rheumatism.

4. While some of the mental disorders are directly due to infections, or are associated with chemical or structural changes in the body, in most of the other however, no such changes can be discovered. They are termed functional and include two of the largest groups of mental disorder, the more severe forms being known as psychoses and the less scvere forms as psycho-neuroses.

Schizophrenia (split mind) and affective reactions (mania and melancholia) collectively termed bio-genetic psychoses, account for at least fifty per cent of the admissions to mental hospitals and for at least a third of the permanent, incurable, population of these public institutions.

5. Psycho-neuroses include a variety of forms of mental ill-health ; hysterias, phobias, anxiety states, obsessional and compulsive neuroses belong to this group as well as problem children, stammerers, certain classes of delinquents and most of those who used to be diagnosed as suffering from shell shock. Psycho-neurosis also accounts for chronic ill-health in many men and women and for many so-called nervous break-downs. The psycho-neurotic condition is often of a mild nature and most persons suffering from it do not find their way into hospitals. Psycho-neurosis is the most important single cause for absenteeism in industry, for unemployment and for poor turn-over in factories. Dr. Halliday the Glasgow Regional Medical Officer of the Department of Health for Scotland under the Insurance Act, discovered that out of 1,000 consecutive cases kept away from work for 12 weeks or more, 33.5 per cent were in what was primarily a psycho-neurotic condition. He showed that the majority of these were certified as suffering from organic diseases including gastritis, debility, anaemia and rheumatism. He estimated that the incidence of psycho-neurosis among the employed males was 28 per cent, while it was 37 per cent among the unemployed. Further, he showed that in one inquiry of 145 consecutive cases described as rheumatic 39·3 per cent, and in another 62 consecutive cases 37 per cent were psycho-neurotic. In a close investigation of the psycho-neuroses of 21 insured persons he established a definite connection between neurosis and rheumatism. Dr. Thomas M. Ling, the Medical Officer of Joseph Lucas Ltd., Birmingham, analysed the case records of 200 consecutive cases of sick employees. He concluded that 27 per cent, who were absent for two or more weeks, were suffering from psycho-neurosis while the period during which another 32 per cent stayed away from work was prolonged by psycho-neurosis. A series of articles in the first three numbers of Vol. X of *The Human Factor*, the organ of the National Institute of Industrial Psychology, by Dr. Garland, provides evidence of a similar character obtained from a factory employing between 2,000 and 3,000 girls. Sir Maurice Cassidy, a consulting cardiologist, has also attributed 29·15 per cent of the cases coming to him to psycho-neurotic causes. It is suspected too, that accident proneness is due to some

form of psychological condition. The Indusrial Health Research Board, for example, have discovered that 75 per cent of the factory accidents generally occur among 25 per cent of the employees. Thus there are evidently many people suffering from mental ill-health which is never diagnosed. Their health and their work often suffer and sometimes they may be even dangerous to their fellow citizens, particularly if they handle dangerous to machinery or drive cars. It is clear that the number of persons suffering from mental disorders of varying degrees of intensity must be much more than those who are admitted and treated in the mental hospitals in England.

6. As regards mental deficiency the Joint Committee of the Board of Education and the Board of Control of Mental Deficiency (commonly known as the Wood Committee) gave in its report, which was issued in 1929, an estimate of about 300,000 mental defectives in England and Wales or 8 per 1,000 of the population.

7. It will be seen that varying degrees of mental ill-health and mental instability affect a much larger section of the community than that which the statistic for mental patients suggest. General medical consultants in large cities in America have found not only that forty to fifty per cent of their consultation concern psycho-neurotic conditions, wherein no organic pathology can be found, but also that purely psychiatric or emotional factors are estimated to cause fifty to sixty per cent of physical illness. Asthma, eczema, gastric ulcer, high blood pressure are a few examples. Hence has sprung a new branch of medicine—psycho-somatic medicine. The expenditure on mental hospitals in America is a billion dollars. It has been estimated that if the time each patient stayed in hospital could be reduced by attention to the emotional factors in physical illness, the annual saving in public expenditure would be several million dollars.

The Result of Treatment

8. In connection with the general impression that the results of treatment in mental diseases are disappointiug, Strecker and Ebaugh (1940) point out that "It is conservatively estimated that between 60 and 75 per cent of

the psychoses which are comparable to what a general physician would designate 'acute' are recoverable. Particularly in psychiatry do we meet conditions and situations which are capable of considerable modification in a favourable direction even though a complete cure may not be effected. This is particularly true in incipient and early Schizophrenia, and the failure to recognise this potentiality has made the outlook seem even gloomier than it really is."

In recent years, an increasing number of articles reporting a high proportion of cures, social remissions, and improvements in incurable patients have appeared. Recent progress in the understanding and treatment of mental disorder has been so spectacular that the chances of recovery of a mental patient can be said to be greater than those of a patient suffering from any other illness. The therapies deserving mention are shock therapy by cardiazol and insulin, continuous narcosis, and exploratory therapy by a sodium pentothal, surgical approach to the brain by sectioning the white matter (leucotomy) and the use of pencillin, hormones, vitamins and direct and indirect psychotherapy.

The Present Position in India

9. The position in India is extremely unsatisfactory. It has been mentioned above that in England, in 1937, the ratio of mental patients treated in hospitals was 3·2 per 1,000 of population, and in America, the rate has varied from 5 to 8 per 1,000 in different years and in different States. These figures give only a rough indication of the extent of prevalence of mental disorder in the two countries. In India there is no reason to believe that the rate of incidence of mental disorder is in any way less than those in England and the United States. While it is true that, in this country, the higher rate of infant mortality and the shorter span of life for the individual should help to produce a smaller proportion of persons liable to adolescent and senile psychoses respectively, there are other factors influencing the development of mental disorder which are operative here to a greater extent than in those two countries. Chronic starvation or under-nutrition, tropical fevers, anæmias,

frequent childbirth in women who are unfit for motherhood are responsible for large numbers of mental breakdown in this country. On the other hand, purely sociological causes may not be operative in India to the same extent as in the other two countries.

In view of these considerations, even if the proportion of mental patients in India be taken as 2 per 1,000 of the population, hospital accommodation should be available for at least 800,000 mental patients. On the other hand there are only a little over ten thousand beds for such patients. The great disparity in respect of mental hospital accommodation between England and India can be shown in another way. In India the existing number of mental hospital beds is in the ratio of one bed to about 40,000 of the population (taking the present population of the country as 400 millions) while, in England, the corresponding ratio is approximately one bed to 300 of the population. Thus the provision in India for the institutional care of insane persons is about 130 times less than that existing in England, even if we estimate the rate of incidence of such cases here as about 37·5 per cent less than the rate in that country. As regards the possible numbers of persons suffering from varying degrees of mental disorder, who may not require hospitalisation and yet should receive trement, and of those suffering from mental deficiency, we have no information at all. It seems, however, almost certain that their numbers are likely to run into some millions in this country if the ratio of incidence in England or America can be taken as even an approximate guide for estimating the numbers of such cases in India. Psychological and medical treatment are necessary for many forms of psycho-neuroses. Mental deficiency will require provision on a wide scale, including special educational facilities and institutional care for children suffering from various forms of this condition and segregation and treatment in institutions for a considerable proportion of mentally deficient adults also. Provision for these two classes of sufferers from mental diseases is almost non-existent in India.

In the previous volume of the report dealing with a review of

health conditions in India we have already referred to the extremely unsatisfactory conditions of some of the existing mental hospitals which, it will be seen, are altogether too few to meet the requirements of the country. Colonel M. Taylor, I. M. S., Medical Superintendent, Ranchi European Mental Hospital, who visited, at our request, all the major mental hospitals in the country and prepared a report for us, says "every mental hospital which I have visited is disgracefully under-staffed. They have scarcely professional workers to give more than cursory attention to the patients." He also states that "Seven of the largest mental hospitals in India have men appointed as superintendents at salaries that a first class mechanic in Tata Works would scorn, six of them have little or no post-graduate experience or training in psychological medicine, and yet these men have been charged with the supervision of large hospitals, and what is more important, human lives. The Deputy Superintendents and subordinate medical staff are utterly untrained in psychiatry." The nursing staff and the ward attendants attached to most of these hospitals are, he points out, insufficiently trained and inadequate in numbers to do efficient service. The use of social workers and the provision of occupational and recreational therapy, which constitute important parts of a modern mental health programme have, speaking generally, received quite insufficient attention in this country.

Our Proposals

10. In putting forward the following proposals we have had the benefit of advice from a small sub-committee, which we appointed, consisting of mental specialists from different parts of India and from Colonel Taylor, to whose report we have already referred. In our view the most important step to be taken is the formulation of a mental health programme for the country after a preliminary investigation of the needs of individual provinces. Such a programme should aim at providing for the community, in successive stages, a modern mental health service embracing both its preventive and curative aspects. As a part

of the implementation of such a programme two of the most urgent needs that should be met are (1) an impovement and augmentation of existing institutional facilities for the treatment of mental ill-health and (2) provision for the training of different types of mental health workers, including doctors and ancillary personnel. With these objects in view we make the following recommendations for the short-term programme :—

(a) the creation of mental health organisation as part of the establishments under the Director-General of Health Services at the Centre and of the Provincial Directors of Health Services ;

(b) the improvement of the existing 17 mental hospitals in British India and the establishment of two new institutions during the first five years and of five more during the next five years ;

(c) the provision of facilities for training in mental health for medical men in India and abroad and for ancillary personnel in India and

(d) the establishment of a Department of Mental Health in the proposed All-India Medical Institute.

(a) The Creation of Mental Health Organisations as part of the Directorate of Health, Central and Provincial:

11. The creation of mental health organisations as part of the establishments of the Director-General of Health Services and of the Provincial Directors of Health Services is, in our view, of such great importance that we have placed it first among our recommendations. The problems of mental health have so far received very little attention in India and we believe, that the appointment of officers with a wide experience of modern developments in this field at the Centre and in the Provinces is essential for the carrying out of preliminary investigations, the formulation of a sound programme of action and its effective implementation. So little information is available regarding the incidence of mental ill-health in the country and the developments in this field of health administration even in the more progressive countries, are so recent that we feel we shall not be justified in attempting to make detailed recommendations regarding the mental health organisation

which the country requires. We must leave this task to the Health Departments who will be guided by the specialists, whose appointment we have suggested.

12. We realise that, with the existing lack of medical men with special training in this subject in India, the appointment of separate mental specialists on the staff of the Director-General of Health Services and of every provincial Director may not be easy. We would suggest that a highly qualified person, with wide experience of the different branches of mental health work, should be appointed on the staff of the Central Directorate of Health and that his advice should be made available to the provinces in the development of their programmes. Until officers with similar qualifications become available for appointment in the provinces, we put forward certain suggestions for an interim arrangement. In a number of provinces mental hospitals exist at their head-quarters. Bombay and Bengal are two notable exceptions among the major provinces. We are, however, suggesting the establishment of a 200-bed mental hospital at Bombay and one at Calcutta with the least practicable delay. As has already been pointed out, in most of the existing mental hospitals the superintendents are medical men without any special training in psychological medicine. We would suggest that steps should be taken, without delay, to appoint to these institutions (including the proposed new hospitals at Bombay and Calcutta) fully qualified mental specialists we can perform the dual function of being the superintendent of the mental hospital at the provincial headquarters and of acting as the adviser to the Director of Health Services on mental health administration. We suggest this arrangement only until qualified mental specialists become available in sufficient numbers to permit the appointment of separate whole-time officials on the provincial Directorates of Health. We believe that the duties in connection with the development of mental health work in a province require the attention of a full time officer.

(b) An Improvement of Institutional Facilities for the Treatment of Ill-Health

13. We were advised by the special Sub-committee that three types of institutions are required for the treatment af mental

patients, viz, (i) hospitals for general mental patients, (ii) homes for mental deficients and (iii) homes for incurables and for senile cases. It has been further suggested that normally, the acommodation provided in an institution of each of these types sould be 1,000 beds. The staff required and the estimates of cost for each type of institution have been worked out for us by the Sub-committee. The capital outlay required on each of these types of institutions is estimated at Rs. 10 lakhs. The annual recurring expenditure per bed is likely to be Rs. 1,000 for a mental hospital, Rs. 700 for a mental deficiency home and Rs. 550 for a home for senile and incurable cases, and the ratio recommended for these three types of institutions is 5:3:2.

14. We are in full agreement with the above recommendations of the Sub-committee as the ultimate objectives to be kept in view. In the meantime, we are putting forward our proposals for the short term programme taking into considerations the existing inadequacy of training personnel and the possible insufficiency of funds. We suggest that radical improvements should be made in the existing mental hospitals in order to make them conform to modern standards. Provision should be made for all the newer methods of diagnosis and treatment. The idea, which is now widely prevalent that these institutions are asylums and serve mainly the purpose of segregating mental patients from the general community, should he replaced by the conception of a hospital, which provides them with all the medical attention and sympythetic handling they require for the improvement of their condition. Apart from such remodelling of existing mental hospitals, we also recommend the creation of seven new institutions during the short-term programme, of which at least two should be established as early as possible during the first five years' period. These are the 200-bed hospitals in Calcutta and Bombay to which we have already referred. As will be seen from our proposals for the development of training facilities they are intended to play an important part in the creation of such facilities.

15. The existing seventeen institutons in British India are hospitals for the treatment of mental disorders. As far as we are aware, no homes of reasonable size and with adequate facilities for

the reception and treatment of mental deficients and of incurables exist in the country. The need for an expansion of mental hospital accommodation is, under existing conditions, so great that we do not wish to suggest that any of the seven new institutions we propose for the establishment during the short-term programme should be homes of either of these two types. A decision on this matter can, however, be left to the Provincial Health Departments after they have had an opportunity of studying carefully the requirements of their provinces and of formulating plans to meet them. As regards the size of the new institutions, we feel that this is also a matter for decision by the Provincial Health Departments. We would, at the same time, suggest for consideration the desirability of limiting their accommodation to approximately 500 beds. Considerations of cost and the need for staffing these new institutions with adequate trained personnel have led us to suggest a smaller bed strength of 500 instead of the 1,000 recommeded by the Sub-committee. For the hospitals at Calcutta and Bombay we have proposed a figure of 200 beds in each case, mainly because of the need for ensuring all possible speed in their establishment in order to develop facilities for training mental health workers. We hope, however, that their expansion may be possible without undue delay.

(c) The Provision of Training Facilties for Medical Men in India and Abroad and for other Types of Mental Health Personnel in India.

16. The urgent need for the training of a large number of medical men and of other personnel for mental health work will be realised from the remarks of Colonel Taylor, which we have already quoted, regarding the unqualified staff now employed in many of the existing mental hospitals. Further, any proposals for an expansion of mental health activity can obviously be carried out only if there be a simultaneous execution of an intensive training programme.

17. As regards medical men, the ultimate aim should be to ensure that all those who are employed in mental institutions should possess a recognised Diploma in Psychological Medicine. It is also desirable that the Superintendent, the Deputy-

Superintendent and Senior Medical Officers in charge of different branches of work in a mental hospital should have a higher degree in Medicine or Surgery such as M. D. or M. S. A proper clinical background in either of these specialities is of advantage to the medical officer even in the treatment of mental patients, because a differential diagnosis of the condition of many of them may often require as much knowledge of general medicine and surgery as of Psychological Medicine. The possibility of error, with serious consequences to the patient, is great in respect of all who specialise only in their narrow fields. To quote Colonel Taylor's words "Every Psychiatrist has seen cases in which eye specialists have tried to correct failing vision by refraction in a patient suffering from General Paralysis of the Insane. Surgeons have frequently been guilty of operations on hysterics and psychiatrists have called the complaints of patients somatic delusions, until they finally died of cancer."

18. One of the purposes of the tour which Colonel Taylor undertook at our request was to make an estimate of existing training facilities in the mental insitutions in the country. In his view such facilities exist on a reasonable scale at Bangalore and at Ranchi. At the former, the mental hospital has, he says, all the essentials for treatment and that it "is recognised as a teaching institution for M. B. B. S., B. A. (Hons.) in Psychology of the Mysore University and the L. M. P. course of the medical school. The hospital is also recognised as a school for post-graduate work and some research work is already being undertaken." It is reported that the staff as a whole has attained a high standard of efficiency. As regards Ranchi, the European Mental Hospital already provides a post-gradute course of instruction which includes Psychiatry (Clinical and theoretical), Forensic Psychology and Mental Hospital Administration. The instruction covers the ground in Psychiatry only, for the Diploma or M. D. in Psychological Medicine of London. This hospital is recognised as a training school for the Diploma in Psychology by the University of London, and a teaching school for nurses by the Royal Medico-Psychological Association. There are no facilities for the study of advanced Anatomy, Physiology,

Histology of the Central Nervous System and Experimental Psychology.

19. We understand that nowhere in this country, are available all the facilities for the starting of a course for the Diploma in Psychological Medicine. We should suggest that, as early as possible, courses of training for this diploma should be developed in Bombay and Calcutta in association with the universities concerned. We have already referred to the desirability of establishing, as early as possible, a 200-bed mental hospital to help in the provision of such facilities. We understand that, in the vicinity of Calcutta, there is a small mental institution, the Lumbini Park Mental Hospital, which is being managed by the Indian Psycho-analytical Society. The visiting physicians are reported to be all highly qualified. But owing to inadequacy of funds, the institution is at present being conducted in such a way as to afford no training facilities. Colonel Taylor states that "this institution, given adequate funds to meet the cost of expansion on modern lines would in time become both a useful hospital and a good teaching school" and we recommend that this development should be assisted and advanced as early as possible. In Bombay the Child Guidance Clinic of the Sir Dorabji Tata Institute of Social Sciences is said to have an encouraging start, although the number of children dealt with is small. Colonel Taylor reports that "This institution will be of great help in the training of both under-graduates and post-graduates in the study of problem children and child psychology". Advanced training in such subjects as Anatomy, Physiology and Histology of the Central Nervous System can be provided in the Medical Colleges in Calcutta and Bombay. We consider that the establishment of a Diploma in Psychological Medicine, with the necessary training facilities at both these places is of the utmost importance. We also suggest that, as soon as possible, similar diploma courses should be developed in the universities of other provincial capitals also.

In this meantime it is highly desirable that a certain number of carefully selected medical men, with some experience of work in mental hospitals in India, should be sent abroad for training. We

suggest that provision should be made for sending at least 20 doctors during the first five years and another 20 during the second five years of our programme.

20. As regards the training of non-medical mental personnel, the types of workers required to be trained are occupational therapists, psychiatric social workers, psychologists, nursing staff and male and female ward attendants. Ranchi already possesses facilities for training occupational therapists. Both at Calcutta and Bombay facilities for the training of psychiatric social workers should be developed. The Sir Dorabji Tata Graduate School of Social Work and the Lumbini Park Mental Hospital, when developed, should be able to participate in such training. The development of facilities for the training of psychologists can, we think, be undertaken in Calcutta where the Applied Section of Psychology of the Calcutta University and the Lumbini Park Mental Hospital can help in such training. The training of nursing staff and of male and female attendants should be undertaken in all mental hospitals in India and the necessary facilities should, we recommend, be developed without delay.

(d) The establishment of a Department of Mental Health in the proposed All-India Medical Institute.

21. The establishment of a Department of Mental Health in the proposed All-India Institute is calculated to serve at least three purposes. These are :—

(1) the development of facilities for the under-graduate and post graduate training of doctors in all branches of psychological medicine and the demonstration to the provincial authorities of the standards to be aimed at, when similar training facilities are created by these authorities within their own territories ;

(2) the promotion of research in the field of mental health ; and

(3) participation in the organisation of a mental health programme for the area in which the Institute is located.

22. All the above three purposes are, to some extent, inter-related. No programme for training workers in mental health will

be complete without the provision of a field training centre, while the development of research in this subject also requires such a centre. The active participation of the Department of Mental Health of the proposed Institute in the organisation of the mental health programme for the area in which it is located will help to secure the facilities for training in the field, the importance of which we have stressed.

The Promotion of Positive Mental Health

23. The pursuit of positive mental health requires the harmonious development of man's physical, emotional and intellectual equipment. Measures designed to create and maintain an environment conducive to healthful living and to control the specific causes responsible for all forms of physical and mental ill-health are essential for promoting such development. The comprehensive programme of health reconstruction which we have recommended in this report, will, if implemented, constitute in itself no small contribution to the development of positive mental health in the community. Apart from provision for the prevention and cure of specific forms of ill-health, physical and mental, many of our proposals, e.g., those dealing with health and physical education, the social aspects of our programmes for mothers and children, for the school-going population and for industrial workers, the removal of slums and the creation of parks and other facilities for promoting community life should also help to raise the level of mental health in the community.

24. The development of an integrated personality, which will help the individual to adjust himself to the stress and strain of life, is essential if sound mental health is to be achieved and maintained. The mental health programme, if properly organised, should be able to assist in the endeavour to secure the unhampered development of human personality. Psychologists are agreed that the child requires a domestic environment which assures it a sense of security "based upon affection, consistency, fairness, regularity and serenity," if its mental development is to proceed on sound lines. At a later stage the child's mental development is also influenced to a large extent by the teacher. An educational

campaign for imparting to parents and teachers knowledge regarding the ways in which they can help the normal mental growth of the children for whom they are responsible, is an essential part of a mental health programme. Such education will supplement the provision that the mental health service will make, through child guidance clinics, to correct unsatisfactory mental or emotional states in children which, if left uncared for, lead to the development of "an aggressive anti-social attitude which is destructive to the personality."

25. The mental health programme should also include within its scope educational propaganda for the adult. Opportunities for self expression through work and recreational facilities are of great importance for the maintenance of a man's mental health. He should therefore be encouraged to create for himself as wide a field of cultural activity as is compatible with his main occupation. The development of hobbies helps to keep alive an active interest in life. A cultivation of the love of nature enables the individual to escape from the cramping limitations of his daily round duties and to obtain, from the changing panorama of Nature, a refreshment which invigorates him without leaving behind any adverse after-effects. The arts also provide a varied field for self-expression outside a person's normal range of duties.

Economic insecurity probably plays a part in preventing the attainment of full mental health in the case of many adults. The view is widely held that unemployment promotes the incidence of psycho-neurotic conditions and some evidence has been advanced in support of this view. The wider aspects of the social security problem are clearly beyond the scope of our investigation. We may, however, draw attention to the fact that the provision of adequate medical care, preventive and curative for the individual, without regard to his ability to pay for it, is becoming recognised in all progressive countries as part of the National Social Security Programme. We have advocated in this report the adoption in India of this objective of a full and free medical service to all.

ABSTRACTS

Self-preservation and the Death Instinct—By Ernst Simmel. (*The Psycho-analytic Quarterly, Vol. XIII, No. 2, 1944*)

The author advances a dualistic theory of instincts which differs to some extent from Freud's theory. He accepts the fundamental conflict between love and hate, but he maintains that the destructive energies of hate are manifestations of self-preservation and not death-instinct. The general tendency found in all the instincts to seek to preserve or reinstate the state of instinct repose or Nirvana by removing stimulus tension, which led Freud to assume the existance of a death instinct, does not represent a tendency to self-destruction according to the author, but to destruction of the object for the preservation of the self. Self-destruction results only when the object-destroying libido withdraws itself from the object due to frustration and makes ego its object. He maintains besides that the death instinct assumed by Freud does not show all the three characteristics which he himself ascribed to an instinct; namely organic source, object and aim. It has the aim of removing excitation, but it has neither an organic source nor an object characteristic of its own, while the specific instinct of self-preservation conceived by the author meets all the threee requirements: its organic source is the gastro-intestinal tract and its aim is to preserve the self. The first satiation of the gastro-intestinal zone through the act of feeding after birth reinstates the prenatal state of complete instinct repose disturbed for the first time by the trauma of birth and this experienc according to the author, not only establishes an association between self-preservation and the tendency to instinct repose but also provides the ego with a pattern for certain later defence reactions. His fundamental thesis in connection with his theory is that the earliest libido organisation is not oral but gastro-intestinal; mouth and anus are merely the terminal parts of this zone, which provide links with the outer world. All the variations of aggression originate from the primitive

demands of this gastro-intestinal zone since its demands can only be met through an aggressive act of devouring. In course of normal development the gastro-intestinal primacy is sub-ordinated to the genital primacy and the primitive cannibalistic object relationship is replaced by a civilized object relationship based on love. The gastro-intestinal primacy, however, never ceases to exert its influence and this results in a conflict between the two primacies persisting throughout life. The ambivalent conflict between love and hate underlying all normal and abnormal phenomena of individual as well as extra individual mental, life thus reflects the conflict between gastro-intestinal and genital primacies. The author brings the destructive energies of the self-preservative instinct in line with the libidinal energies by ascribing to the self-preservative instinct the same aim as that of the libido, namely, to synthesize living substances; the self-preservative instinct seeks to achieve this aim within the self, whereas the sex instinct extends beyond the self.

The author offers some evidence to show the validity of his theory and briefly reviews the generally accepted theory of neuroses and psychoses in the new light. He says that Freud himself opened the field of research but did not enter it on account of his pre-occupation with sociological phenomena during his last years. He believes that Freud applied his concept of death instinct to the problems of mass psychology before clinically verifying its validity in individual life, and that if he had lived longer he would have, sooner or later, come to the same conclusion as his.

B. DESAI

NOTES AND NEWS

With the introduction of the new policy in the British Broadcasting Corporation, prominence is given in radio talks to subjects which were formerly tabooed. Religion, society, morals, etc. are now being discussed occasionally from the rationalistic standpoint. Psycho-analysis has also received a greater recognition than before. A member of the Institute of Psycho-analysis, London, who spoke anonymously, gave a very interesting and popular account of the theoretical and practical aspects of psycho-analysis some time back. It is not giving away any secret when we mention that Dr. John Rickman was the speaker. In India, fortunately, there has been no opposition hitherto against radio talks on psycho-analysis and allied subjects. The late Mr. M. N. Banerji, Prof. H. P. Maiti, Dr. S. C. Mitra and other members of the Indian Psycho-analytical Society spoke on the radio on various occasions on the different aspects of psycho-analysis. The talk on the psychology of the gambler given by Mr. Banerji and that on the psychology of the criminal by Dr. S. C. Mitra created wide interest.

Articles and books on psycho-analysis both in the Indian languages and in English are appearing in greater number than before. G. Bose's Bengali book *Swapna* (Dreams) and S. C. Mitra's book *Manahsamikshan* in the same language have been enjoying wide popularity. G. Bose's English book *Everyday Psychoanalysis* which appeared in December 1945 has already been sold out and a second edition is expected. There has been a great demand for reprints of psycho-analytical articles read in the past before the Indian Psycho-analytical Society and also for those published by the members of the Society in the different periodicals here. Dr. Ernest Jones in his Foreword in the first number of this Journal wrote "Periodicals are the very life-blood of science. By them knowledge is circulated better than in any other way, and—what is more—they effect a permanent record to which recourse can be had at a later date." Indian Psycho-analytical Society is desirous of preserving in a readily accessible permanent form the contributions of its members hitherto made on psycho-analysis. Samiksa

has been contemplating to collect all such published and unpublished articles and to print them in a separate section when the necessary permission has been obtained from the parties concerned.

* * * * * * *

A "School For Children In Need Of Special Care," has been started at Ravi Lodge, Warden Road, Bombay, since September 1944.

The school is run with the assistance of an Advisory Committee consisting of :

Dr. R. N. Cooper, M.S. (Lond.), F.R.C.S. (Eng.), Dean, Wadia Hospital for Children, Bombay

Dr. K. R. Masani, M.R.C.S. (Eng.), L.R.C.P. (Lond.), D.P.M. (Eng.), Hony. Psychiatrist, J. J. Group of Hospitals, and Director, Indian Institute of Psychiatry and Mental Hygiene, Bombay

Dr. Lalkaka, M.B.B.S., Capt., Late I.M.S., Hony. Psychiatrist, K. E. M. Hospital, Bombay

Dr. Miss K. H. Cama, M.A. (Bom.), M.Sc., Ph. D. (Mich. U.S.A.), Bombay

Dr. and Mrs. H. M. Vakeel

As the salaries of teachers and necessary equipment, etc., involve considerable expense, the following rules as regards fees, etc., have been provisionally made. The same are subject to alteration from time to time as may be deemed necessary by the Management.

The rules are as follows :—

(1) The school hours are from 10-30 a. m. to 4-30 p. m.

(2) The fees for each pupil per month (*including vacations*) are Rs. 65/- for any child attending from 10-30 a.m. to 4-30 p.m. and Rs. 40/- for any child attending from 10-30 a.m. to 12-30 p.m. or 2-30 p.m. to 4-30 p.m.

(3) Books, stationery, and *special* equipment will be provided at cost.

(4) The holidays shall be as follows :—
About 1½ months from April to June, about 15 days in September or October, and about 4 to 5 weeks in December and January.

(5) Extra fees will be charged for any child wishing to take dancing and physical training.

(6) Two Months' Notice will be required if any child wishes to leave school.

(7) All girls will be required to wear white blouses and coloured pinafores and boys white shirts and navy-blue pants.

CONTENTS OF VOL. I, 1947

Page

ARTICLES

The Genesis of the Super-ego. Ernest Jones ... 3
'All or None' Attitude in Sex. G. Bose 13
Notes on Oral and Phallic Elements in a Single Analytical Hour. E. G. Servadio 27
A Note about Teaching Psycho-analysis. M. Grotjahn 39
The Story of the Light that disappeared. Geza Roheim 51
On Sublimation. Melitta Schmideberg 97
The Nature and Genesis of Love. G. Bose ... 119
The History of the Aggression-Impulse. Edward Hitschmann 137
War-marriage. Edmund Bergler 142
Auto-eroticism in Paranoia. N. N. Chatterji ... 149
The Mother Complex in Literature. C. D. Daly ... 157
Hindu Treatise on Kali. C. D. Daly 191
A Short Note on Mutual Masturbation. T. C. Sinha 197
Psychoanalytical Interpretation of Animal Behaviour. G. Bose 209
The Psychology of Man's Attitude Towards Woman. C. D. Daly 231
Symbolism in the Drawing of a Transvestite. M. Grotjahn 241
Psychological Testings, its Practical and its Heuristic Significance. D. Rapaport 245
Nature of Paranoid Delusions. N. N. Chatterji ... 263
Manmatha Nath Banerji, 1887-1946. 271
Fear of Leaving the Apartment. Edmund Bergler ... 281
Garo Songs. T. C. Sinha 285
Some Aspects of the Unconscions in Hysteria. N. De 299
Prof. Freud : The Beginning of a Case History. Paul Federn 305
Memorandum on the Problems of Prevention & Treatment of Mental Disorders submitted to the Medical Relief Advisory Committee of the Health Survey & Development Committee, Govt. of India. G. Bose 312
Extracts from the Recommendations of the Bhore Health Survey and Development Committee Govt. of India 325

ABSTRACTS 87, 205, 273, 341

BOOK REVIEW—

Everyday Psycho-analysis. G, Bose (S. C. Mitra) ... 86
Psychology of Woman I. H. Deutsch (C. V. Ramana) ... 278
Population, Psychology and Peace. J. C. Flugel (B. K. Bose) 279
Nirgana Mana. N. N. Chattopadhaya (A. Datta) ... 280

Page

INDIAN PSYCHO-ANALYTICAL SOCIETY : Report ... 94, 207

LIST OF AUTHORS

Bergler, Edmund. Fear of Leaving the Apartment ... 281
War Marriage 142
Bhore Health Survey & Development Committee, Extracts 325
Bose, G. 'All or None' Attitude in Sex ... 13
Memorandum on the Problems of Prevention & Treatment of Mental Disorders submitted to the Medical Relief Advisory Committee of the Health Survey & Development Committee, Govt. of India ... 312
Psychoanalytical Interpretation of Animal Behaviour ... 209
Chatterji, N. N. Auto-eroticism in Paranoia ... 149
Nature of Paranoid Delusions ... 263
Daly, C. D. Hindu Treatise on Kali 191
The Mother Complex in Literature 157
The Psychology of Man's Attitude Towards Woman 231
De, N. Some Aspects of the Unconscious in Hysteria 299
Federn, Paul. Prof. Freud : The Beginning of a Case History 305
Grotjahn, Martin. A Note about Teaching Psychoanlysis 39
Symbolism in the Drawing of a Transvestite 241
Hitschmann, Edward. The History of Aggression-Impulse 137
Jones, Ernest. Foreward 1
The Genesis of the Super-ego ... 3
Rapaport, David. Psychological Testings, its Practical and its Heuristic Significance ... 245
Roheim, Geza. The Story of the Light that disappeared 51
Schmideberg, Melitta. On Sublimation ... 97
Servadio, E. G. Notes on Oral and Phallic Elements in a Single Analytical Hour ... 27
Sinha, T. C. A Short Note on Mutual Masturbation 197
Garo Songs 285

REPORT OF

INDIAN PSYCHO-ANALYTICAL SOCIETY

At a Council Meeting held on the 9th October 1947, Mr. Ramanlal Patel was elected a member of the Society; Mr, Rajpat Bhatia, M.A. of 52, Queensway, New Delhi and Mr. K. C. Mukherji, M.A. of the Department of Psychology, Calcutta University were elected associate members of the Society; and Mr. B. X. Tsatos was declared to have duly passed the Certificate Examination.

At a General Meeting held on the 11th October 1947, the resolutions passed by the Council on the 13th March 1947 regarding increase in the subscription rate from 1948 were confirmed; and the following paper was read by Dr. N. N. Chatterji:

"Ingestion and Excretory Megalomania."

At a Council Meeting held on the 18th December 1947, Miss Myra Sen, B.A. of 56, Harrison Road, Calcutta was elected an associate member of the Society; and Mrs. Dolly K. Irani was permitted to take up control work.

CHANGE OF ADDRESS :

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